

CERTIFICATE OF DEATH

Reg. Dist. No.

7044

06997

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u>	
c. LENGTH OF STAY IN 1b <u>10 days</u>		d. STREET ADDRESS <u>10901 BORNEDALE RD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anthony</u> Middle <u>John</u> Last <u>Abel</u>		4. DATE OF DEATH Month <u>6</u> Day <u>23</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-25-09</u>
9. AGE (In years lost birthday) yrs. <u>50</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter - self</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jack Abel</u>		14. MOTHER'S MAIDEN NAME <u>Hilda Raines</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>Armed</u> <u>1942-1945</u>		16. SOCIAL SECURITY NO. <u>579-22-6225</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Tamponade Suspected</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>10 days</u> <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. m.</u> Month <u>19</u> Day <u>19</u> Year <u>1960</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 13, 6</u> , 19 <u>60</u> , to <u>June 23</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 23</u> , 19 <u>60</u> , and that death occurred at <u>12:00</u> <u>noon</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stephen F. Patten</u>		DATE SIGNED <u>6/23/60</u>	
PHYSICIAN'S NAME (Type) <u>STEPHEN F. PATTEN</u>		<u>Silver Spring Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/28/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. Washington, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 27 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>

74



Wm. E. Bliss Co. 100 pages, 100 pages

Wm. E. Bliss Co. 100 pages, 100 pages

Wm. E. Bliss Co. 100 pages, 100 pages

Wm. E. Bliss Co. 100 pages, 100 pages

Wm. E. Bliss Co. 100 pages, 100 pages

Wm. E. Bliss Co. 100 pages, 100 pages

Wm. E. Bliss Co. 100 pages, 100 pages

Wm. E. Bliss Co. 100 pages, 100 pages

Wm. E. Bliss Co. 100 pages, 100 pages

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Item 1 File G264 6-10-60 et

06998

Reg. Dist. No.

2019

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1402 Dilston Road</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 16</u> d. STREET ADDRESS <u>1402 Dilston Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BESSIE</u> First <u>ABRAHAM</u> Middle Last 4. DATE OF DEATH Month <u>JUNE</u> Day <u>6</u> Year <u>1960</u>				5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>MAR. 15, 1900</u> 9. AGE (In years lost birthday) <u>60</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> 11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>NATHAN BANNER</u> 14. MOTHER'S MAIDEN NAME <u>EVA. — —</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>—</u> INFORMANT <u>(SON)</u> Address <u>NORMAN ABRAHAM - 1020-QUEBEC TERR. S.S. MD.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Gall Bladder</u> <u>1951</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Heart Disease.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Dec. 1, 1959</u> to <u>June 6, 1960</u> , that I last saw the deceased alive on <u>June 2, 1960</u> , and that death occurred at <u>9:30</u> A.M., from the causes and on the date stated above. ACTUAL SIGNATURE <u>William S. Miller</u> M.D. <u>1835 Eye St. N.W.</u> DATE SIGNED PHYSICIAN'S NAME (Type) <u>William S. Miller</u> <u>Wash D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>6-7-60</u> 22c. NAME OF CEMETERY OR CREMATORY <u>ELESAVETGRAD CEMETERY</u> 22d. LOCATION (City, town, or county) (State) <u>WASHINGTON - D.C.</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>B. DANZANSKY & SONS - 3501-14th St. N.W.</u> 24a. REC'D BY REGISTRAR <u>DATE JUN 8 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

16

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE BOARD OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7091

CERTIFICATE OF DEATH

66999

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Montgomery General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Adelia Middle M. Last Alinutt		4. DATE OF DEATH Month June Day 10 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1878
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Housework	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Aden D. Alinutt		14. MOTHER'S MAIDEN NAME Martha Virginia Duvall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	
17. INFORMANT Mrs. Mollie M. Childs-Derwood, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 4-22-2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocarditis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 10 hr 10 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 10 19 60 to June 10 19 60 , that (I) (we) last saw the deceased alive on June 10 19 60 , and that death occurred at 11:40 A.M. from the causes and on the date stated above.			
22a. SIGNATURE A. D. Bonifant		22b. DATE SIGNED June 14 '60	
22c. PHYSICIAN'S NAME (Type) A. D. BONIFANT		22d. ADDRESS Sandy Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-13-60	
23c. NAME OF CEMETERY OR CREMATORY Laytonsville Meth.		23d. LOCATION (City, town, or county) (State) Laytonsville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber		25a. REC'D BY REGISTRAR JUN 14 '60	
ADDRESS Laytonsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

(M)

100°

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

Note: Montgomery County Medical Examiner Dr. Broschart notified and will approve.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
7020 Item 9 2116205 6-17-60 of											
CERTIFICATE OF DEATH											
07860											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Iowa b. COUNTY Winnescheik						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring					c. LENGTH OF STAY IN 1b 8 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Decorah, Iowa				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2208 Osborn Drive					d. STREET ADDRESS RFD # 4			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELLA Middle GERTRUDE Last AMUNDSON					4. DATE OF DEATH Month JUNE Day 11 Year 1960						
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 13, 1895		9. AGE (In years last birthday) 65 64 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Iowa			12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME Peter Olie Helgeson					14. MOTHER'S MAIDEN NAME Nellie Bagne						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) --		17. INFORMANT E. L. Overholt, Lt. Col., USA(MC)		Address Same as # 1					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 9 - 1960 to June 11, 1960 , that (I) (we) lost the deceased alive on June 11, 1960 and that death occurred at 9:35 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Richard L. Hench					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED June 11, 1960				
22c. PHYSICIAN'S NAME (Type) Richard L. Hench					22d. ADDRESS Staff, Walter Reed General Hosp. Washington 12, D. C.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/16/60		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State) Decorah, Iowa				
24. FUNERAL DIRECTOR'S SIGNATURE Rinaldi Funeral Home, Inc.					ADDRESS 816 H St., NE, Wash. 2, DC		25a. REC'D BY REGISTRAR JUN 14 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

0205

(M)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07001

7045

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mont</u> Middle <u>Clyde</u> Last <u>Andrews</u>				4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-8-74</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>19</u> Min.	IF UNDER 24 HRS. Months <u>3</u> Days <u>3</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - U.S. Govt.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Steven Andrews</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Etchman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> [If yes, give war or dates of service]				16. SOCIAL SECURITY NO. <u>medical Records</u>		17. INFORMANT Address <u>medical Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral edema</u> 443X DUE TO (b) <u>Hypertensive Heart disease & failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Gout</u> INTERVAL BETWEEN ONSET AND DEATH <u>acute</u> <u>old</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>June 3</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 3</u> , 19 <u>60</u> , and that death occurred at <u>9:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ernest A. Sarac</u> M.D.				ADDRESS (Street, city or town, state) <u>7006 N. H. Ave. TK-PK Md.</u> DATE SIGNED <u>6/3/60</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Ernest A. Sarac</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>6-6-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Fraw</u> ADDRESS <u>3166 Diamond</u>				24a. REC'D BY REGISTRAR <u>Arthur L. Fraw</u> DATE <u>JUN 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Fraw</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

17

CENTRAL OFFICE

CHIEF

RECORDS

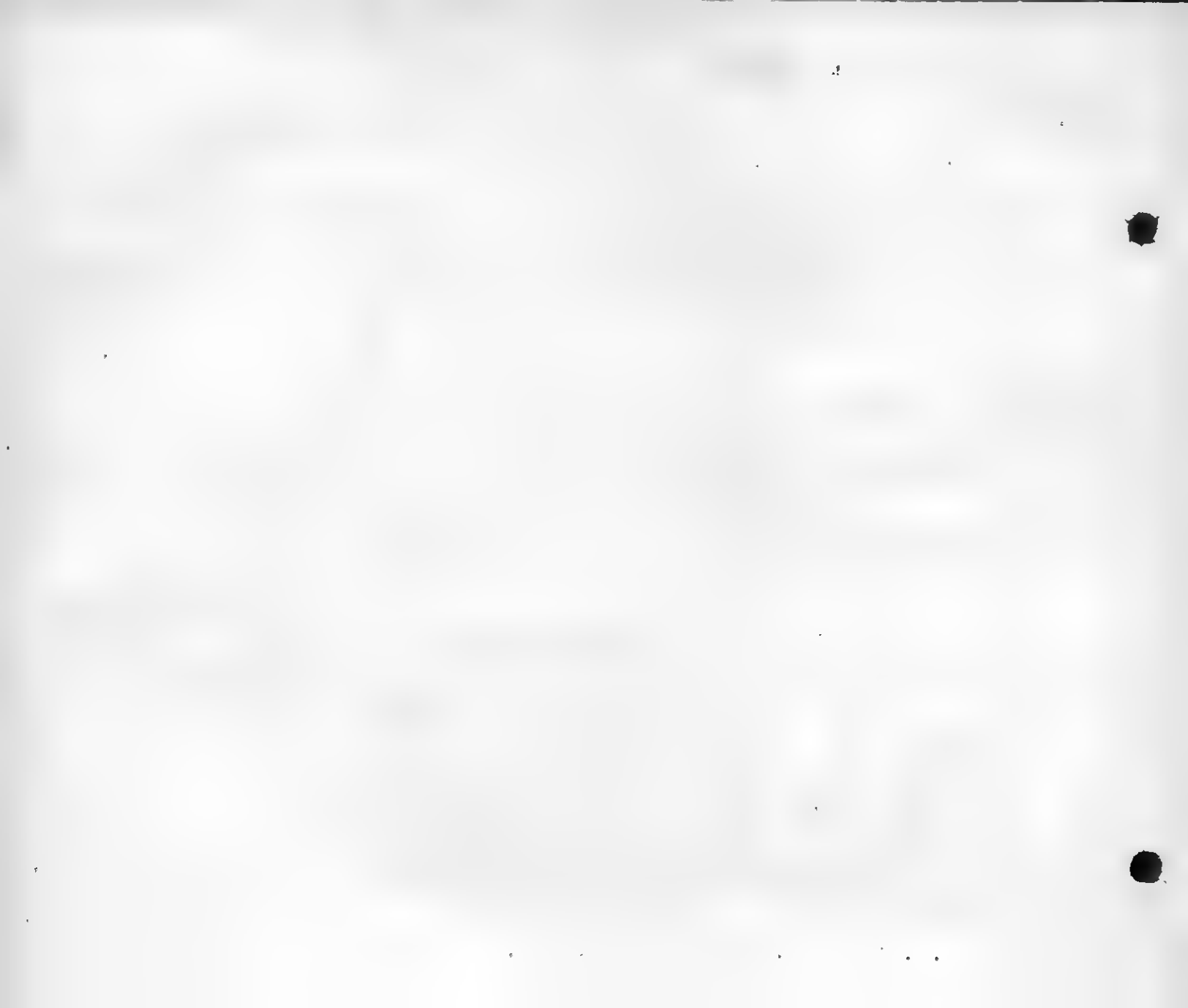
1911



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remain in the funeral home. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7068 CERTIFICATE OF DEATH 07063

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4800 Montgomery Avenue				e. STREET ADDRESS 4800 Montgomery Avenue			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Channell Last Barker				4. DATE OF DEATH Month June Day 28 Year 1960			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/29/1881	9. AGE (In years last birthday) 78 yrs	IF UNDER 1 YEAR Months 7 Days 18 Hours 18 Min 18	IF UNDER 24 HRS Months 7 Days 18 Hours 18 Min 18	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hous ewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Channell				14. MOTHER'S MAIDEN NAME Sophia Somers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Wash. DC Betty Barker Reed- 6674 32nd Street, N.W.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Rupture, abdominal aorta DUE TO Bone marrow syphilis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 hours 7 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA LEFT BREAST							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JAN. 30, 1959 to JUNE 28, 1960 that (I) (we) last saw the deceased alive on JUNE 28, 1960 , and that death occurred at 12:40 PM , from the causes and on the date stated above.							
22a. SIGNATURE Robert G. Angle				22b. DATE SIGNED JUNE 28, 1960		22c. PHYSICIAN'S NAME (Type) Robert G. Angle	
22d. ADDRESS 5009 Del Ray Avenue, Bethesda, Md.							
23a. BURIAL, CREMATION, or MOVEMENT (Specify) Burial		23b. DATE THEREOF 6/30/60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. - 2901 14th St., N.W.				25a. REC'D BY REGISTRAR DATE JUN 29 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	
Washington, D.C.							



DATE **JUN 14 '60** *Arthur S. Kress*

X

+

7093

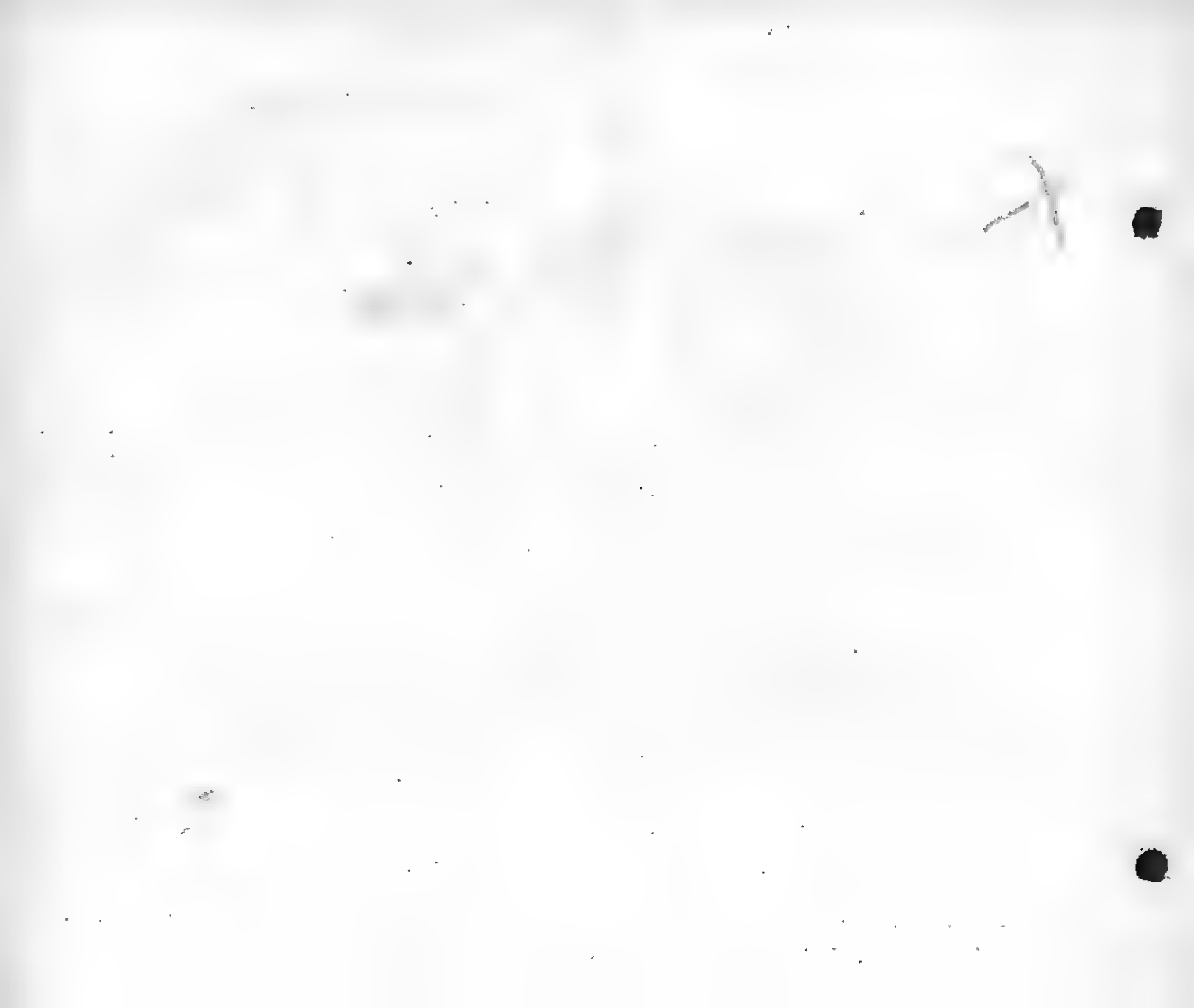
CERTIFICATE OF DEATH

Reg. Dist. No. 67061

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Chia Vista Nursing Home</u>		d. STREET ADDRESS <u>12121 Glen Mill Road</u>	
3 NAME OF DECEASED (Type or print) <u>ROLLA KENT Beattie</u>		4. DATE OF DEATH <u>June 2 1960</u>	
5 SEX <u>male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 14 1875</u>
9 AGE (In years last birthday) <u>85</u>		10. IF UNDER 1 YEAR <u>4</u> Months <u>18</u> Days <u>18</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plant Pathologist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GOV'T</u>	
11. BIRTHPLACE (State or foreign country) <u>?</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James A. Beattie</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Bontly?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
INFORMANT <u>Daughter</u>		Address <u>12121 Glen Mill Rd. Rockville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Int</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>C.V. accident</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 19</u> to <u>June 2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 1</u> , 19 <u>60</u> , and that death occurred at <u>9:45</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William H. Killay</u>		ADDRESS (Street, city or town, state) <u>9902 Counselman Rd.,</u> DATE SIGNED <u>June 2, 1960</u>	
PHYSICIAN'S NAME (Type) <u>William H. Killay</u>		<u>Potomac, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>6-3-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>W. H. 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

0706

7094

1. PLACE OF DEATH o COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE <u>md</u> b COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington Grove</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>07 Washington Grove</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>108 Grove Ave</u>		d. STREET ADDRESS <u>108 Grove Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Mabel Lillian Becraft</u>		4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 14 1893</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles E. Becraft</u>		14. MOTHER'S MAIDEN NAME <u>Kate B. Penn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
INFORMANT <u>Helen Bean (sister)</u>		Address <u>Stn 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>End-arteritis (left leg)</u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>years</u> <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1950</u> to <u>6-13</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6-13</u> , 19 <u>60</u> , and that death occurred at <u>3:50 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F.J. Broschart</u>		M.D. <u>8. Russell Ave</u>	
PHYSICIAN'S NAME (Type) <u>F.J. Broschart</u>		<u>Garthursburg, md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-16-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>	22d. LOCATION (City, town, or county) (State) <u>Garthursburg md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Jarman</u>		24a. REG'D BY REGISTRAR DATE <u>JUN 15 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7069 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8, 9 fill in 7069 6-10-60 at

07067

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> c. LENGTH OF STAY IN b. <u>8 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7017 W. Greenvale Parkway</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> d. STREET ADDRESS <u>7017 W. Greenvale Parkway</u>	
3. NAME OF DECEASED (Type or print) <u>Anthony Andrew Benevento</u> 4. DATE OF DEATH <u>June 9 1960</u>		5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>Sept. 9, 1904</u> 8. AGE (In years last birthday) <u>57</u> 9. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> 10. IF UNDER 24 HRS Hours <u>2</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>lawyer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Comm.</u> 11. BIRTHPLACE (State or foreign country) <u>Conn.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Frank Benevento</u> 14. MOTHER'S MAIDEN NAME <u>Antonetta Gentile</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>Yes-Unknown</u> 17. INFORMANT <u>Dolores Benevento</u> Address <u>Item 2</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>4:30</u> p.m. <u>01</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>6-10-60</u> Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>6/13/60</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u> 22d. LOCATION (City, town, or country) (State) <u>Silver Spring, Maryland</u>		24a. REC'D BY REGISTRAR <u>June 14 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey Bethesda, Maryland</u>			

51

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7095 CERTIFICATE OF DEATH

07068

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Florida b. COUNTY Volusia X			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 28 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. STREET ADDRESS No street address			
3. NAME OF DECEASED (Type or print) First Lillie Middle Viola Last Bennett				4. DATE OF DEATH Month June Day 17 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27, 1902	9. AGE (in years lost birthday) 58 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Florida		
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Edward Rossie				
14. MOTHER'S MAIDEN NAME Surena Henry			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				
16. SOCIAL SECURITY NO. 263-48-4676			17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Post operative status: Total pelvic exenteration DUE TO (c) Epidermoid carcinoma of the cervix						INTERVAL BETWEEN ONSET AND DEATH 1 hour 8 days 11 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)			(County)		(State)		
21. I certify that (I) (this hospital) attended the deceased from May 20, 1960 to June 17, 1960 , that (I) (we) last saw the deceased alive on June 17, 1960 , and that death occurred at 1:15 AM from the causes and on the date stated above.							
22a. SIGNATURE Edward D. McLaughlin M.D.			ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 6/18/60		
22c. PHYSICIAN'S NAME (Type) Edward D. McLaughlin, M.D.			22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.				
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial-transit 6-19-60		6-19-60		Seville Cemetery		Volusia County, Florida	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY			ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR DATE JUN 21 '60		
					25b. REGISTRAR'S SIGNATURE Arthur S. Kneass		

MEDICAL CERTIFICATION

TO HOSTS OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



7021

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2809 Dennis Ave.				d. STREET ADDRESS 2809 Dennis Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Leonard M. Biggs, Sr.				4. DATE OF DEATH June 9 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/10/83	
9. AGE (In years last birthday) 76 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocery store				10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry M. Biggs				14. MOTHER'S MAIDEN NAME Alice L.W. Bremerman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO Leonard M. Biggs, Jr. same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Arteriosclerotic Heart Disease DUE TO (c) 10 yrs INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 4 , 19 60 , to June 9 , 19 60 , that I last saw the deceased alive on June 9 , 19 60 , and that death occurred at 1 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 11800 Ga Ave SE Md DATE SIGNED June 9, 1960							
ACTUAL SIGNATURE M. F. OTTMAN M.D.							
PHYSICIAN'S NAME (Type) M. F. OTTMAN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/11/60		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington, 9, D.C.				24a. REC'D BY REGISTRAR DATE JUN 13 '60		24b. REGISTRAR'S SIGNATURE Charles S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

40

CERTIFICATE OF DEATH

Reg. Dist. No.

07010

7022

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTG.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRG.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4104 / SBELL ST.</u>		d. STREET ADDRESS <u>1 4104 / SBELL ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MAX</u> Middle <u>-</u> Last <u>BLASER</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>10</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL-8-1884</u> 106 yrs.
9. AGE (In years, months, days, hours, minutes) <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ACCOUNTANT</u>	11. BIRTHPLACE (State or foreign country) <u>CZECHOSLOVAKIA</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>NOAH BLASER</u>	
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-</u>	
16. SOCIAL SECURITY NO. <u>178-05-2157</u>		17. INFORMANT <u>LILLIE BLASER</u> Address <u>4104 / SBELL ST</u> <u>SSA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of colon & rectum</u> 152.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>-</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5-3</u> 19 <u>60</u> , to <u>6-10</u> 19 <u>60</u> , that I last saw the deceased alive on <u>6-7</u> 19 <u>60</u> , and that death occurred at <u>10:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Abraham W. Danish</u> M.D.		ADDRESS (Street, city or town, state) <u>927 Rushing Rd Silver Spring, Md</u> DATE SIGNED <u>6-10-60</u>	
PHYSICIAN'S NAME (Type) <u>ABRAHAM W. DANISH</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/12/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NATL. MEM. PARK</u>	22d. LOCATION (City, town, or county) (State) <u>FALLS CHURCH, VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bedding Funeral Home</u> ADDRESS <u>4217-9th Xee</u>		24a. REC'D BY REGISTRAR <u>JUN 13 60</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Reese</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7096
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE New York b. COUNTY Queens			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 18 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 2441 Curtis Street			
3. NAME OF DECEASED (Type or print) First Alfred Middle (none) Last Bonsignore, Jr.				4. DATE OF DEATH Month June Day 9 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1930	9. AGE (In years last birthday) yrs 30	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Alfred Bonsignore, Sr.				14. MOTHER'S MAIDEN NAME Pauline (Canassi ?)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Unascertainable			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac failure during operation DUE TO 415X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic mitral insufficiency DUE TO (c) 10 years				INTERVAL BETWEEN ONSET AND DEATH 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from May 22 , 19 60 , to June 9 , 19 60 , that I last saw the deceased alive on June 9 , 19 60 , and that death occurred at 2:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center, Bethesda 14, Maryland DATE SIGNED 6/9/60							
ACTUAL SIGNATURE Roland Folse M.D.				PHYSICIAN'S NAME (Type) Roland Folse, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Bur-Transit		6/10/60		St. Raymonds Cemetery		Bronx County, New York	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUN 13 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hanks			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07012

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 7	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2202 Darrow Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Maurice Elmer Boren		4. DATE OF DEATH Month June Day 5 Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/23/1903
9. AGE (In years last birthday) 56 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Personal Dept.		11b. KIND OF BUSINESS OR INDUSTRY Dept. Store Woodward & Lothrop	
11c. BIRTHPLACE (State or foreign country) Nebraska		12. C. TIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Maurice Elmer Boren		14. MOTHER'S MAIDEN NAME Mabel Bagg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no or unknown no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 506-18-6091	
17. INFORMANT Mary Margaret Boren--		Address 2202 Darrow St. Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I: DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1 Hour DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) None			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Apr 1954 to June 5, 1960 , that (I) (we) last saw the deceased alive on June 5, 1960 , and that death occurred at 3P M, from the causes and on the date stated above.			
22a. SIGNATURE John Lawrence Avery M.D.		22b. DATE SIGNED June 5, 1960	
22c. PHYSICIAN'S NAME (Type) John Lawrence Avery		22d. ADDRESS 1010 Georgia Ave., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/8/1960	23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	23d. LOCATION (City, town, or county) (State) Montgomery County, Md.
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. - 2901 14th St. N.W. Washington, D.C.		25a. REC'D BY REGISTRAR JUN 7 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

40

CERTIFICATE OF DEATH

Reg. Dist. No.

07013

7097

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY in 1b <u>X</u> <u>Damascus</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>CURT</u> Middle <u>WILLIAM</u> Last <u>BOYLES</u>				4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1966</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/1/60</u>	9. AGE (In years last birthday) <u>0</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min.	IF UNDER 24 HRS Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert W. Boyles</u>				14. MOTHER'S MAIDEN NAME <u>Debra Elyard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		INFORMANT <u>Debra Elyard</u> Address <u>(same as above)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>immaturity + prematurity</u> DUE TO (c) <u>Intraventricular hemorrhage</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>6/1/60</u> , 19 <u>60</u> , to <u>6/2/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6/2/60</u> , 19 <u>60</u> , and that death occurred at <u>7:20 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Vincent L. O'Donnell</u>				ADDRESS (Street, city or town, state) <u>8218 Wisconsin Ave</u> DATE SIGNED <u>6/2/60</u>			
PHYSICIAN'S NAME (Type) <u>Vincent L O'Donnell</u>				8218 Wisconsin Ave. Bethesda, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/7/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 8 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

X

7098

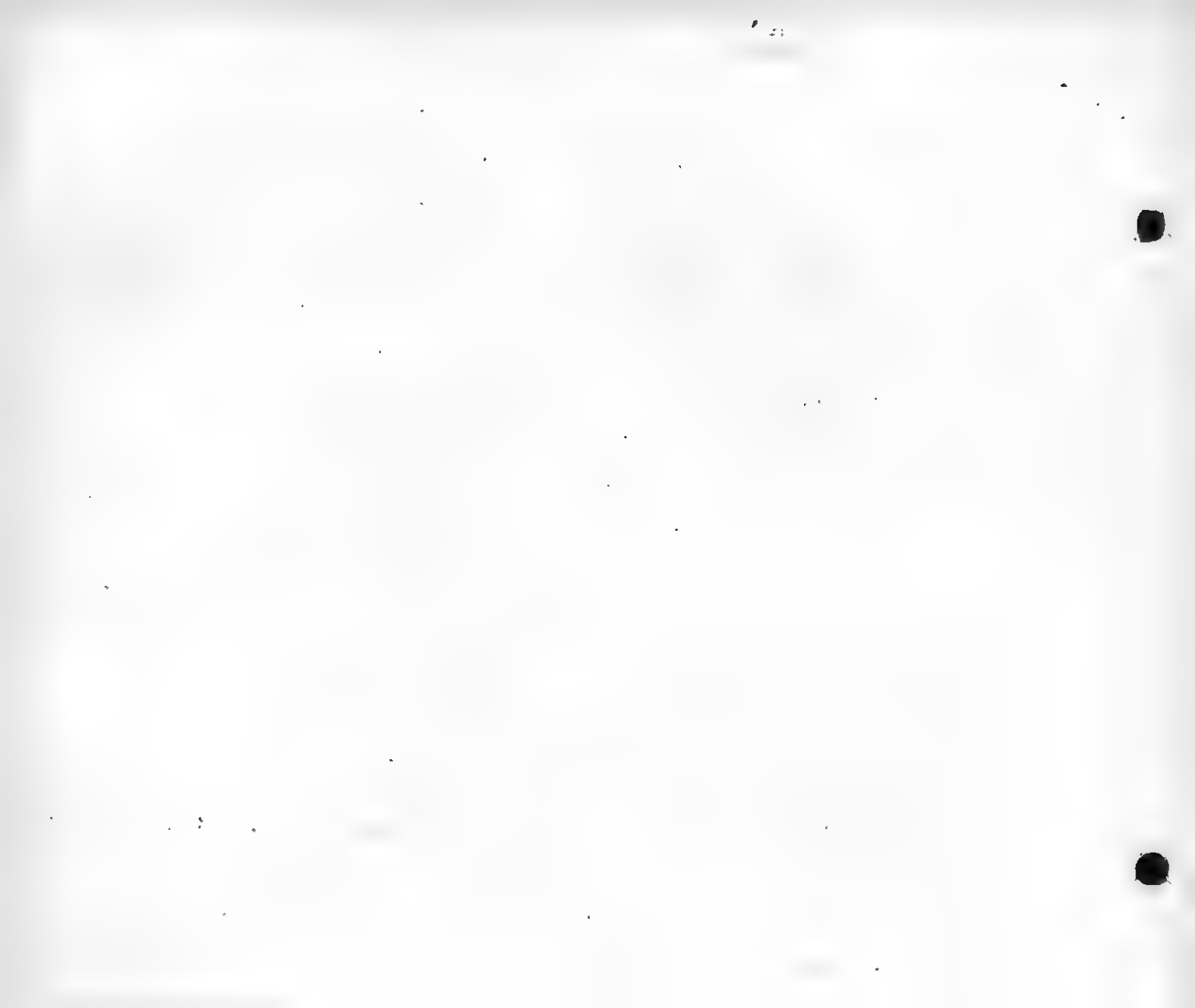
CERTIFICATE OF DEATH

07013

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
c. LENGTH OF STAY IN 1b 3 days				d. STREET ADDRESS 3817 22nd. St. N.E.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Ch ester Orville Bradley				4. DATE OF DEATH Month Day Year June 13 19 60			
5 SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/18/01	
9 AGE (In years lost birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) G lazier				10b. KIND OF BUSINESS OR INDUSTRY Circle Glass Co.		11. BIRTHPLACE (State or foreign country) Wash. D.C	
12 CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME Georg e A. Bradley				14. MOTHER'S MAIDEN NAME Nettie Landon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO yes-Unknown			
17. INFORMANT M rs. Virginia Bradley				Address Wife) Same as Above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Bilateral ureteral Obstruction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Carcinoma (Primary in Colon) (c) Unknown							INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days Unknown
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 28, 1959 , to June 13, 1960 , that I last saw the deceased alive on June 13, 1960 , and that death occurred at 12:30 AM, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Old Georgetown Rd. Beth. Md				DATE SIGNED 6/13/60			
ACTUAL SIGNATURE John E. Ball				M.D. Old Georgetown Rd. Beth. Md			
PHYSICIAN'S NAME (Type) John Ball							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/17/60		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR JUN 16 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kimes			

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

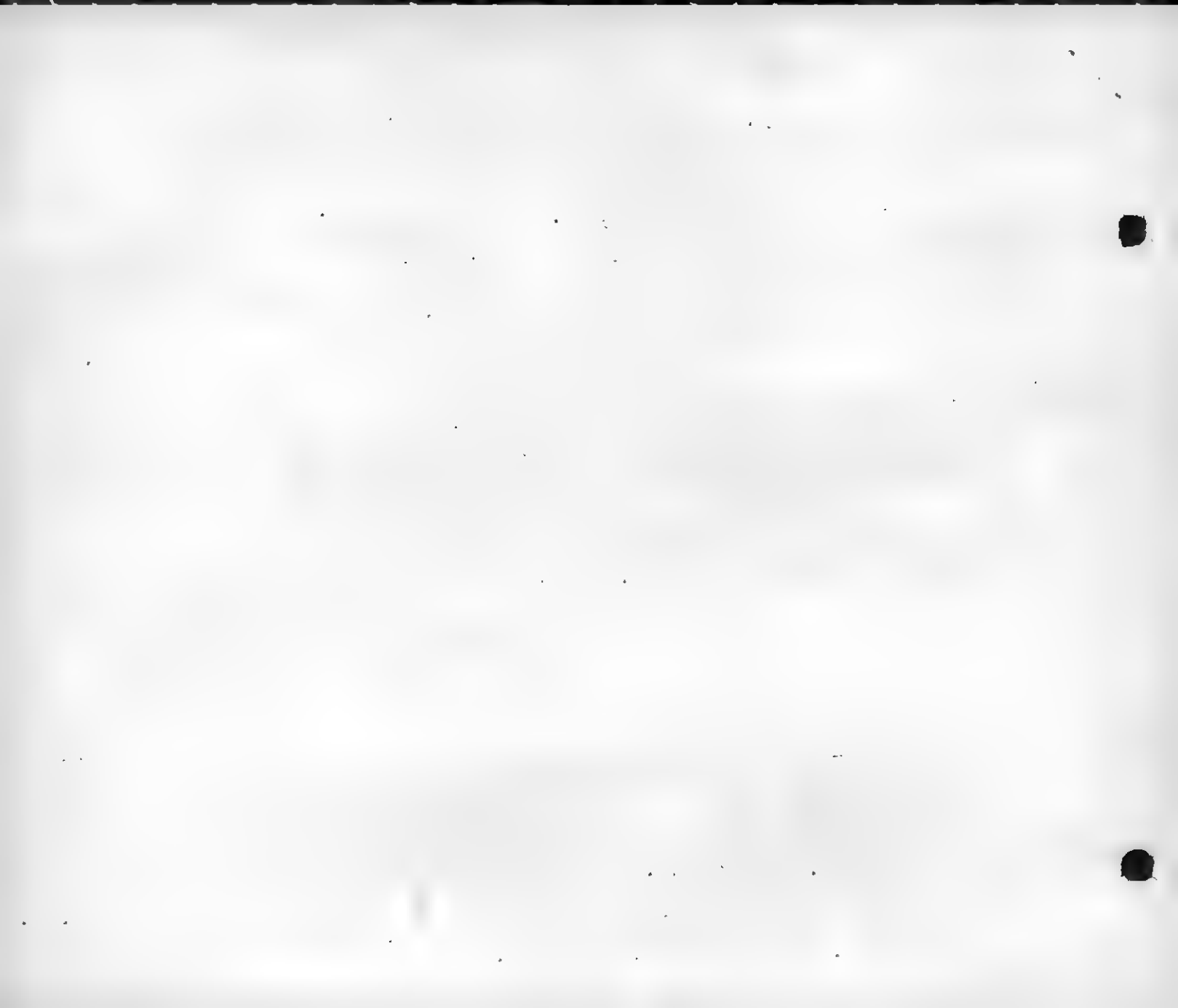
7099

CERTIFICATE OF DEATH

07015

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>125 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>North Dakota</u> b. COUNTY <u>Grand Forks</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grand Forks</u> d. STREET ADDRESS <u>1507 North Fourth Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Leroy</u> Middle <u>Harold</u> Last <u>Bratlie</u>			4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1960</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>June 4, 1931</u>			
9. AGE (In years last birthday) <u>29</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fire Company</u>			
11. BIRTHPLACE (State or foreign country) <u>North Dakota</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Ruben Bratlie</u>			
14. MOTHER'S MAIDEN NAME <u>Iva Goria</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1952-1954</u>					
16. SOCIAL SECURITY NO. <u>Unascertainable</u>				17. INFORMANT Address <u>The Medical Record The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO (b) <u>Intracerebral hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Aplastic anemia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u> <u>minutes</u> <u>2 days</u> <u>6 months</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour <u>11</u> a. m. <u>13</u> p. m. 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from February 2, 1960, to June 13, 1960, that (I) (we) last saw the deceased alive on June 13, 1960, and that death occurred at 11:15 p.m. from the causes and on the date stated above							
22a. SIGNATURE <u>Norman R. Gevirtz</u> M.D.				22b. DATE SIGNED <u>6/14/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>Norman R. Gevirtz, M.D.</u>				22d. ADDRESS <u>The Clinical Center Maryland National Institutes of Health, Bethesda 14</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 6-15-60</u>		23b. DATE THEREOF <u>6-15-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bethany Cemetery</u>			
23d. LOCATION (City, town, or county) (State) <u>Grand Forks County, N. D.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u> <u>Bethesda, Md.</u>					
25a. REC'D BY REGISTRAR DATE <u>JUN 20 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07216

7100

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton Md.</u>				c. LENGTH OF STAY IN 1b <u>6 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wheaton Nursing Home</u>				d. STREET ADDRESS <u>1005 Sigsgood Rd., 71 E.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Anne Cecilia Brennan</u>				4. DATE OF DEATH Month Day Year <u>June 22 1960</u>			
5. SEX <u>fe</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 17, 1890</u>	
9. AGE (In years last birthday) <u>69</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Patrick Brennan</u>				14. MOTHER'S MAIDEN NAME <u>Mary Murray</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mary Twomey - 1005 Sigsgood Rd. N.E.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Pyelonephritis</u> <u>150.0</u> DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>5 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ischemic atherosclerosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>March 1957</u> to <u>June 22, 1960</u> that (I) (we) last saw the deceased alive on <u>June 21, 1960</u> and that death occurred at <u>9:00 AM</u> from the causes and on the date stated above							
22a. SIGNATURE <u>Francis P. Hannon M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>June 22, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANCIS P. HANNON</u>				22d. ADDRESS <u>1511-1757 A.W. H. 75H. IX</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6-24-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		23d. LOCATION (City, town, or county) (State) <u>WASH. D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Hannon</u>				ADDRESS <u>3831-GA. AVE.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 30 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove for burial papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7024

07017

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 3 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3006 Dawson Avenue		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
		d. STREET ADDRESS 3006 Dawson Avenue	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARK Middle FERGUSON Last BROWN		4. DATE OF DEATH Month June Day 20 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/13/88
		9. AGE (In years last birthday) 72 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supply Clerk (retired)		10b. KIND OF BUSINESS OR INDUSTRY U.S. Naval Gun Factory	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PERRY FRANKLIN BROWN		14. MOTHER'S MAIDEN NAME MARGARET BAKER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give year or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mr. Carl D. Crist, 3006 Dawson Ave.		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Coronary Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 4 years DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH none	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Oct. 30, 1956 to June 20, 1960 that (I) never saw the deceased alive on June 18, 1960 and that death occurred at 6:45 PM from the causes and on the date stated above.			
22a. SIGNATURE M. van Kinsbergen M.D.		22b. DATE SIGNED June 20, 1960	
22c. PHYSICIAN'S NAME (Type) M. van Kinsbergen		22d. ADDRESS 29 Grant Circle, N.W., Washington, D.C.	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/24/60	
23c. NAME OF CEMETERY OR CREMATORY BROOKEVILLE CEMETERY		23d. LOCATION (City, town, or county) (State) BROOKEVILLE, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, INC.		25a. REC'D BY REGISTRAR DATE JUN 27 '60	
ADDRESS SILVER SPRING, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Kins	

7

12. 31.

11

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
c. LENGTH OF STAY IN 1b <u>5 days</u>		d. STREET ADDRESS <u>8308 Greenwood Avenue</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Loretta</u> Middle <u>Jean</u> Last <u>Brummett</u>		4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 19, 1960</u>
9. AGE (In years last birthday) <u>74</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>6</u> Days <u>11</u> Hours <u>41</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>newborn</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Henry Allen Brummett</u>		14. MOTHER'S MAIDEN NAME <u>Alice Jean Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>mother</u>	
17. INFORMANT <u>mother</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>prematurity, cardio vascular</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>collapse, septicemia</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>192-4</u>			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 19, 1960</u> , to <u>June 24, 1960</u> , that I last saw the deceased alive on <u>June 24, 1960</u> , and that death occurred at <u>12:50 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Marvin I. Mones</u> M.D.		DATE SIGNED <u>June 24, 1960</u>	
PHYSICIAN'S NAME (Type) <u>Marvin I. Mones, M.D.</u>		<u>927 Pershing Drive, Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>	22b. DATE THEREOF <u>6-28-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium & Hosp. Takoma Park</u>	22d. LOCATION (City, town, or county) (State) <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Hare, M.D.</u>		ADDRESS <u>Washington Sanitarium & Hosp</u>	
24a. REC'D BY REGISTRAR <u>June 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7101

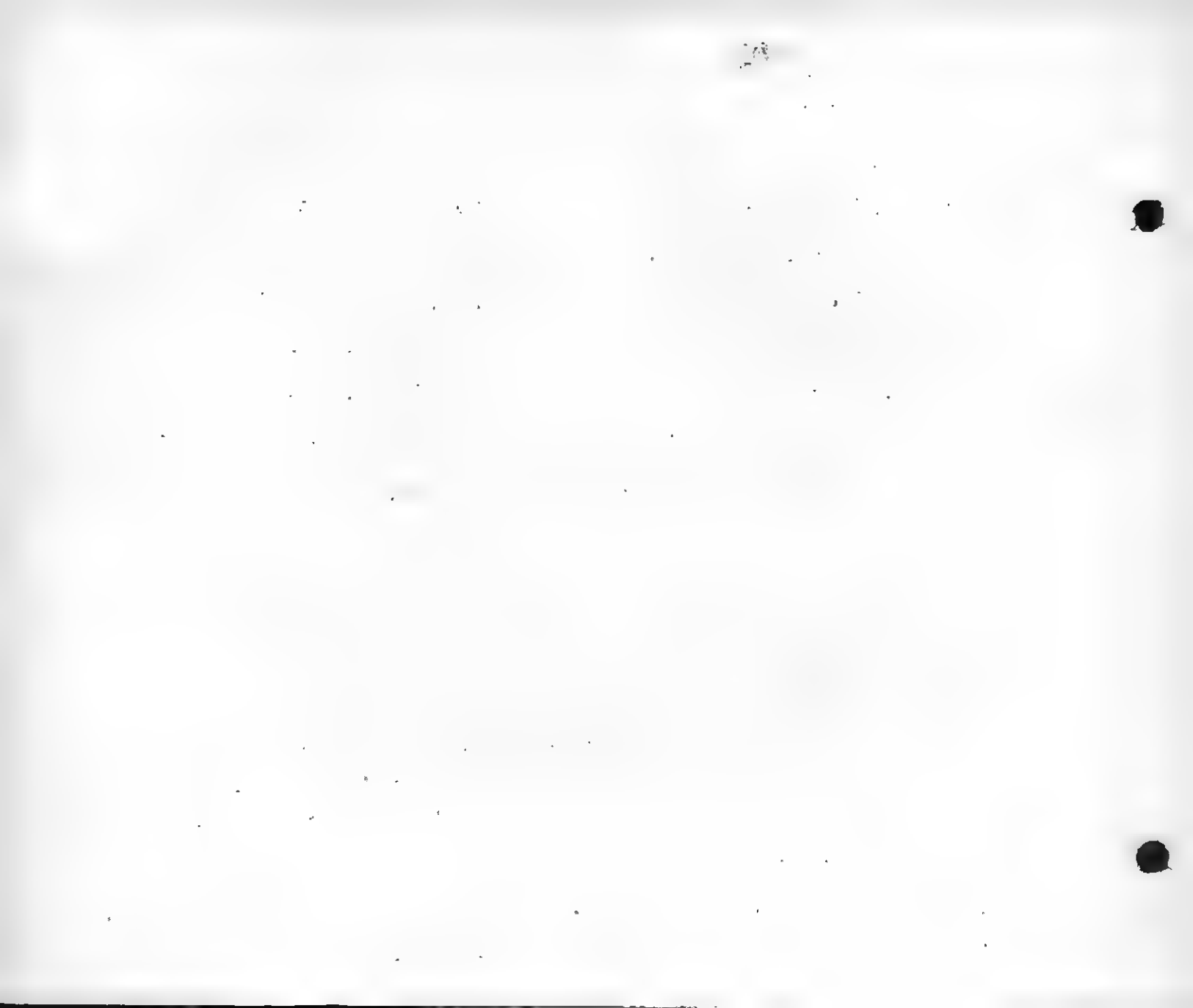
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institut on Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Browningsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Browningsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD #1, Monrovia		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Willie Middle H. Last Burdette		4. DATE OF DEATH Month June Day 30 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5, 1866
9. AGE (In years lost birthday) 93 yrs		10. IF UNDER 1 YEAR Months 93 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Hyattstown, Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John E. Burdette		14. MOTHER'S MAIDEN NAME Mary E. Watkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Milton W. Burdette, Monrovia, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 15 years DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 15 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/15, 1954 to 6/30, 1960 that I last saw the deceased alive on 6/29, 1960 , and that death occurred at 11:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James P. Kerr		ADDRESS (Street, city or town, State) Damascus, Md.	
PHYSICIAN'S NAME (Type) James P. Kerr		DATE SIGNED 7/1/60	
22a. BURIAL, CREMATON, REMOVAL (Specify) Burial		22b. DATE THEREOF July 2, 1960	
22c. NAME OF CEMETERY OR CREMATORY Bethesda Methodist		22d. LOCATION (City, town, or county) (State) Browningsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Moberg		ADDRESS Damascus, Md.	
24a. REC'D BY REGISTRAR JUL 5 '60		24b. REGISTRAR'S SIGNATURE Carlton L. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07020

7025

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE _____ b. COUNTY _____				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			c. LENGTH OF STAY IN 1b _____		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, DC			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1800 Grace Church Rd.				d. STREET ADDRESS 1724 Newton St NW		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Sarah E Byrne				4. DATE OF DEATH Month Day Year June 15 1960				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 19, 1868		
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		
10b. KIND OF BUSINESS OR INDUSTRY _____				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Leonidas Jones				14. MOTHER'S MAIDEN NAME Elizabeth King				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO _____		17. INFORMANT Mrs Pauline Cissel Address 1519 Monroe St NW. DC		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Long standing heart failure DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Stenosis DUE TO _____ (c) Chronic sclerotic heart disease DUE TO _____							INTERVAL BETWEEN ONSET AND DEATH 6 mos 5 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary edema - chronic poisoning							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that (I) (this hospital) attended the deceased from Jan. 27, 1960, to June 15, 1960, that (I) (we) last saw the deceased alive on June 15, 1960, and that death occurred at 3:30 PM, from the causes and on the date stated above.				
22a. SIGNATURE J. E. VERNSTEIN				22b. DATE SIGNED 6/15/60		22c. PHYSICIAN'S NAME (Type) J. E. VERNSTEIN		
22d. ADDRESS 3311-16 N.W. Wash 10. DC				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				
23b. DATE THEREOF 6/18/60		23c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery		23d. LOCATION (City, town, or county) (State) Beallsville, Maryland				
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.				25a. REC'D BY REGISTRAR JUN 17 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

7102

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>14508-Windsor Lane</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ernest F. Callahan</u>		4. DATE OF DEATH Month Day Year <u>June 13 1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEP 5, 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs		10. IF UNDER 1 YEAR <u>9</u> Months <u>5</u> Days <u>5</u> Hours <u></u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Interstate Commerce</u> <u>md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edward Patrick Callahan</u>		14. MOTHER'S MAIDEN NAME <u>Anna Shaffer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>Wm. T. Strahan - 220 - Univ. Blvd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>57R</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 Hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>50</u> , to <u>June</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 11</u> , 19 <u>60</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>6/13/60</u>	
PHYSICIAN'S NAME (Type) <u>LEO I DOWMAN MD</u>		ADDRESS (Street, city or town, state) <u>8218 WISC AVE Bethesda 14 Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/17/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>Bethesda, Maryland</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>		DATE JUN 16 '60	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
7103 CERTIFICATE OF DEATH									
Reg. Dist. No. 07022									
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>				
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					c. LENGTH OF STAY IN 1b <u>3 days</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>					d. STREET ADDRESS <u>Route #2 Emory Grove</u>				
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>BENNETT</u> Last <u>CAMPBELL</u>					4. DATE OF DEATH <u>JUNE 29</u> 19 <u>60</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>hepo</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/16/60</u>		9. AGE (In years last birthday) yrs. <u>13</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>NOT GIVEN</u>					14. MOTHER'S MAIDEN NAME <u>DORIS ELAINE CAMPBELL</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give year or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT Address <u>MOTHER</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]									INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO <u>173.3</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Immaturity</u> DUE TO <u>Immaturity</u> (c) <u>Immaturity</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/17/60</u> , 19 <u>—</u> , to <u>6/29/60</u> , 19 <u>—</u> , that I last saw the deceased alive on <u>6/29/60</u> , 19 <u>—</u> , and that death occurred at <u>3:20 AM</u> , from the causes and on the date stated above									
ACTUAL SIGNATURE <u>Vincent J. Donnell</u> M.D.					ADDRESS (Street, city or town, state) <u>8218 Wisconsin Ave Bethesda Md</u>				
PHYSICIAN'S NAME (Type) <u>—</u>					DATE SIGNED <u>6/30/60</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-2-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brookside</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattsville, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Newden</u> ADDRESS <u>Rockville Md</u>					24a. REC'D BY REGISTRAR <u>—</u> DATE <u>JUL 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

20 74 16 1XV



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

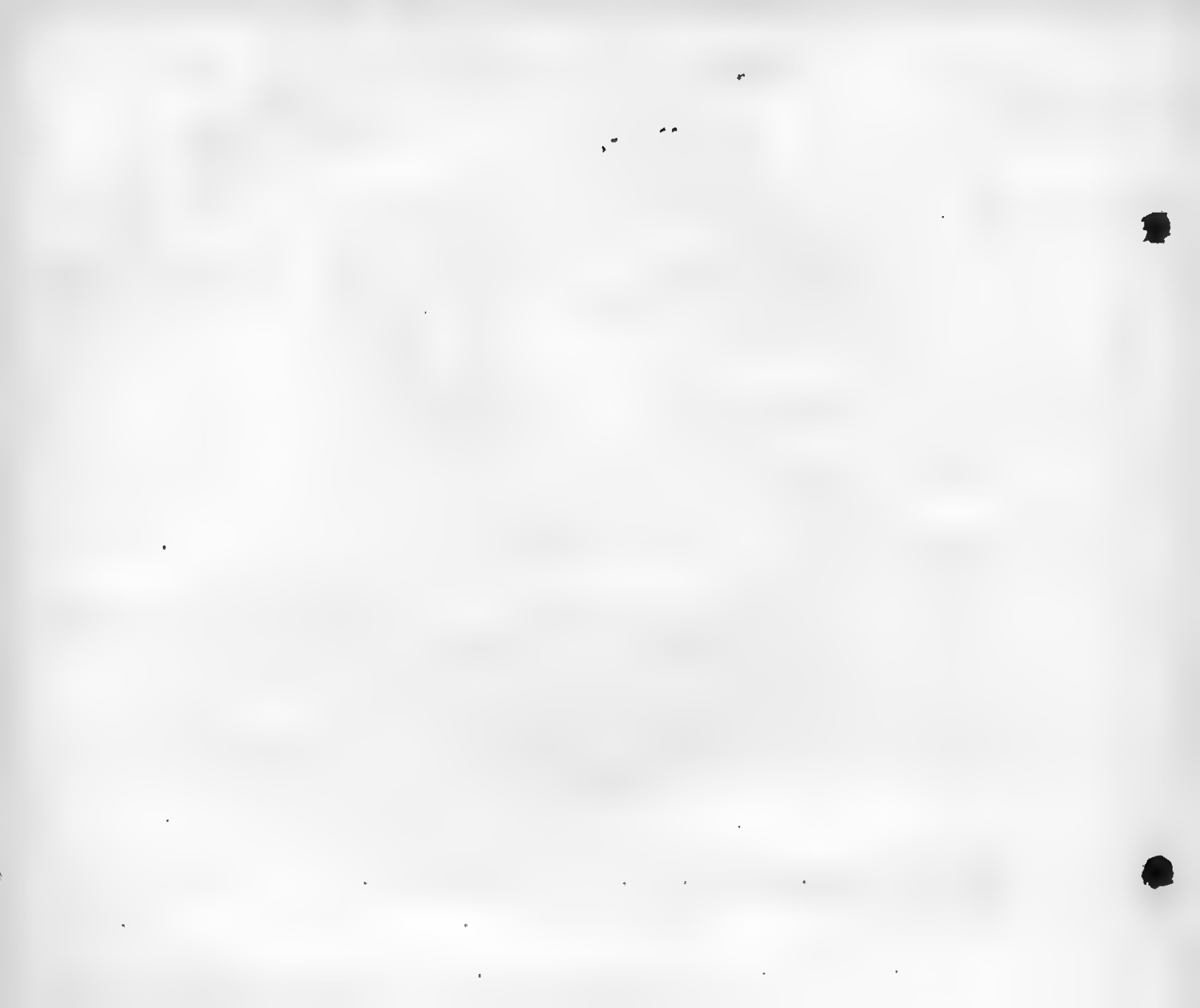
7047
CERTIFICATE OF DEATH

Reg. Dist. No.

17023

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN lb 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 1325 Grandin Avenue e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First (baby) Middle Carle Last Carle		4. DATE OF DEATH Month June Day 13 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1960
9. AGE (In years last birthday) yrs. 36		IF UNDER 1 YEAR Months 15 Days 15 IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) baby		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) United States		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Michael Theodore Carle		14. MOTHER'S MAIDEN NAME Jacqueline Trik Monroe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) no		16. SOCIAL SECURITY NO. Mother	
17. INFORMANT Mother		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARNOLD-CHIARI DEFECT 152X DUE TO HYDROCEPHALUS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DILATATION OF RIGHT ATRIUM		INTERVAL BETWEEN ONSET AND DEATH AT BIRTH AT BIRTH	
20a. DILATATION WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12:55pm June 13, 1960 to 1:10pm June 13, 1960 , that I last saw the deceased alive on June 13, 1960 , and that death occurred at 1:10pm , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ira W. Pearlman M.D.		ADDRESS (Street, city or town, state) 4700 Bradley Blvd., Chevy Chase, Maryland	
DATE SIGNED JULY 5, 1960			
PHYSICIAN'S NAME (Type) Ira W. Pearlman, M.D.		4700 Bradley Blvd., Chevy Chase, Maryland	
22a. BURIAL CREMATION, REMOVAL (Specify) cremation	22b. DATE THEREOF 6-27-60	22c. NAME OF CEMETERY OR CREMATORY Washington San & Hosp.	22d. LOCATION (City, town, or county) (State) Takoma Park Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M.D., Washington San & Hosp.		ADDRESS Washington San & Hosp.	
24a. REC'D BY REGISTRAR JUL 11 '60		24b. REGISTRAR'S SIGNATURE Chilton S. Hume	

2075292XV3



7104

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 6 days 10 Hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Earl S Carter		4. DATE OF DEATH Month June Day 16 Year 1960	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/10/07
9. AGE (In years last birthday) 52 yrs		10. IF UNDER 1 YEAR Months 6 Days 6 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Mont. County Board of Education	
11. BIRTHPLACE (State or foreign country) Gaithersburg, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elliott Carter		14. MOTHER'S MAIDEN NAME Lula Selby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214403-6959	
17. INFORMANT Mrs. Edna M. Carter		Address 905 Baltimore Rd. Rockville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right Coronary Thrombosis DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Thrombosis DUE TO (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 4 days 6 days Indef.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 - 9 , 19 60 , to 6 - 16 , 19 60 , that I last saw the deceased alive on June 16 , 19 60 , and that death occurred at 6:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8218 Wisconsin Ave 1 DATE SIGNED 6-16-60			
ACTUAL SIGNATURE Francis C. Mayle Jr.		PHYSICIAN'S NAME (Type) FRANCIS C. MAYLE JR	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/20/60	
22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR JUN 20 60		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11

11

CERTIFICATE OF DEATH

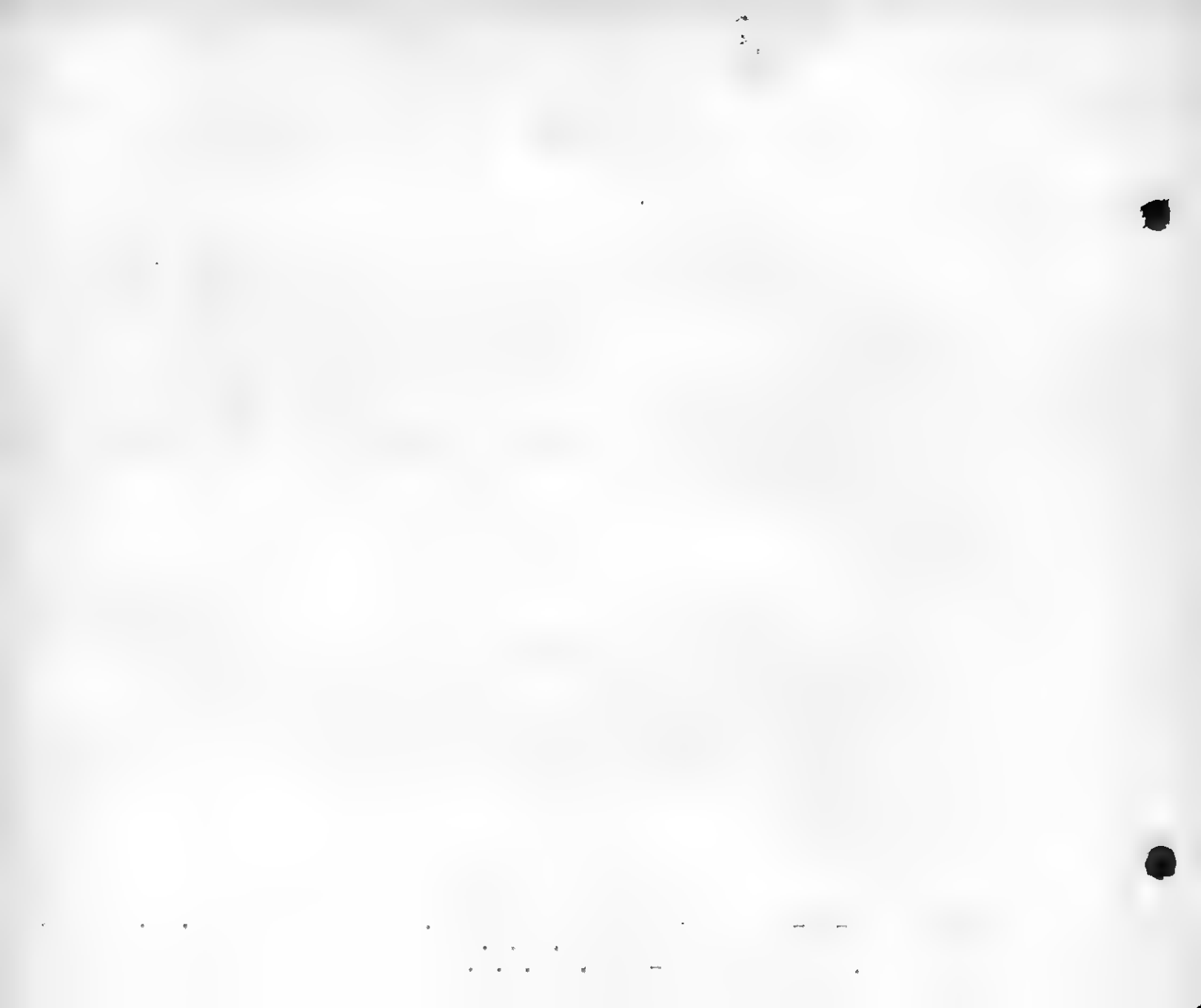
Reg. Dist. No.

7048

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAROMA PARK				c. LENGTH OF STAY IN 1b 10 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 517 ALBANY AVE. (OAK HAVEN)				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. HYATTSVILLE			
				d. STREET ADDRESS 8108-14th AVE.			
3. NAME OF DECEASED (Type or print) CAROLINA First Middle Last ATANIA				4. DATE OF DEATH Month JUNE Day 16 Year 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 12, 1877	
9. AGE (in years lost birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ITALY	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ANTHONY VILARDO				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. YES			
INFORMANT KATE DI PASQUA-8108-14th. AVE. Address WEST HYATTS. MD.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 2nd DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emilia DUE TO (c) malnutrition							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) central nervous system							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10/5, 1959 to 6/16, 1960 , that I last saw the deceased alive on 6/16, 1960 , and that death occurred at 2 p.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE Francis J. Collins M.D.				ADDRESS (Street, city or town, state) 418 University Blvd. E. DATE SIGNED 6/16/60			
PHYSICIAN'S NAME (Type) FRANCIS J. COLLINS				Simon J. Magi, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-21-60		22c. NAME OF CEMETERY OR CREMATORY GATES OF HEAVEN CEM.		22d. LOCATION (City, town, or county) (State) WESTCHESTER CO. N.Y.C. N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins ADDRESS WASH. D.C.				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
FRANCIS J. COLLINS 3821-14th. ST. N.W.				DATE JUN 20 '60		Arthur E. Hume	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7049 CERTIFICATE OF DEATH 07026

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>9 days</u>		d. STREET ADDRESS <u>7714 Midhurst Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanit Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MR. Alfred Randolph Clarke</u>		4. DATE OF DEATH Month <u>6</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-22-83</u>
9. AGE (In years last birthday) <u>76</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>	
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Alfred Clarke</u>		14. MOTHER'S MAIDEN NAME <u>Annie E. Wicker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>HEMORRHAGE, MASSIVE, POSTOPERATIVE, INTRAABDOMINAL</u> 467			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
DUE TO			
DUE TO			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NEPHROSIS, CHRONIC, BILATERAL, WITH RIGHT STAGHORN CALCULUS</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>1928</u> to <u>6/3</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>6/30</u> 19 <u>60</u> , and that death occurred on <u>6/30</u> M, from the causes and on the date stated above			
22a. SIGNATURE <u>Dean H. Harding</u> M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Dean H. Harding</u>		22d. ADDRESS <u>113 CHAPMAN ST NW WASHINGTON D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/2/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		ADDRESS <u>2901-14th NW Washington D.C.</u>	
25a. REC'D BY REGISTRAR <u>JUL 1 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7105 CERTIFICATE OF DEATH

07025

1. PLACE OF DEATH a. COUNTY Montgomery		b. STATE MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Virginia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 64 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annandale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 202 Chapel Drive			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Steele		Middle Simmons		Last CLARKE		4. DATE OF DEATH Month June	
Day 21		Year 19 60					
5 SEX Female	6 COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-8-20		9. AGE (In years lost birthday) 40 yrs	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert R. SIMMONS				14. MOTHER'S MAIDEN NAME Jessie STEELE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. 238-12-0757		17. INFORMANT Address (H) Robert A. Clarke, same as #2 above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of breast - metastases 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS A AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 15 mos							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) person attended the deceased from April 18 19 60 to June 21 19 60 . that (I) person saw the deceased alive on June 21 19 60 , and that death occurred at 6:50PM M, from the causes and on the date stated above.							
22a. SIGNATURE E. J. Rupnik		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-22-60			
22c. PHYSICIAN'S NAME (Type) E. J. RUPNIK, CDR, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 6-23-60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town, or county) (State) Suitland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Jos. Gawler's & Sons, 1756 Pa. Ave., NW, WashDC				25a. REC'D BY REGISTRAR JUN 24 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

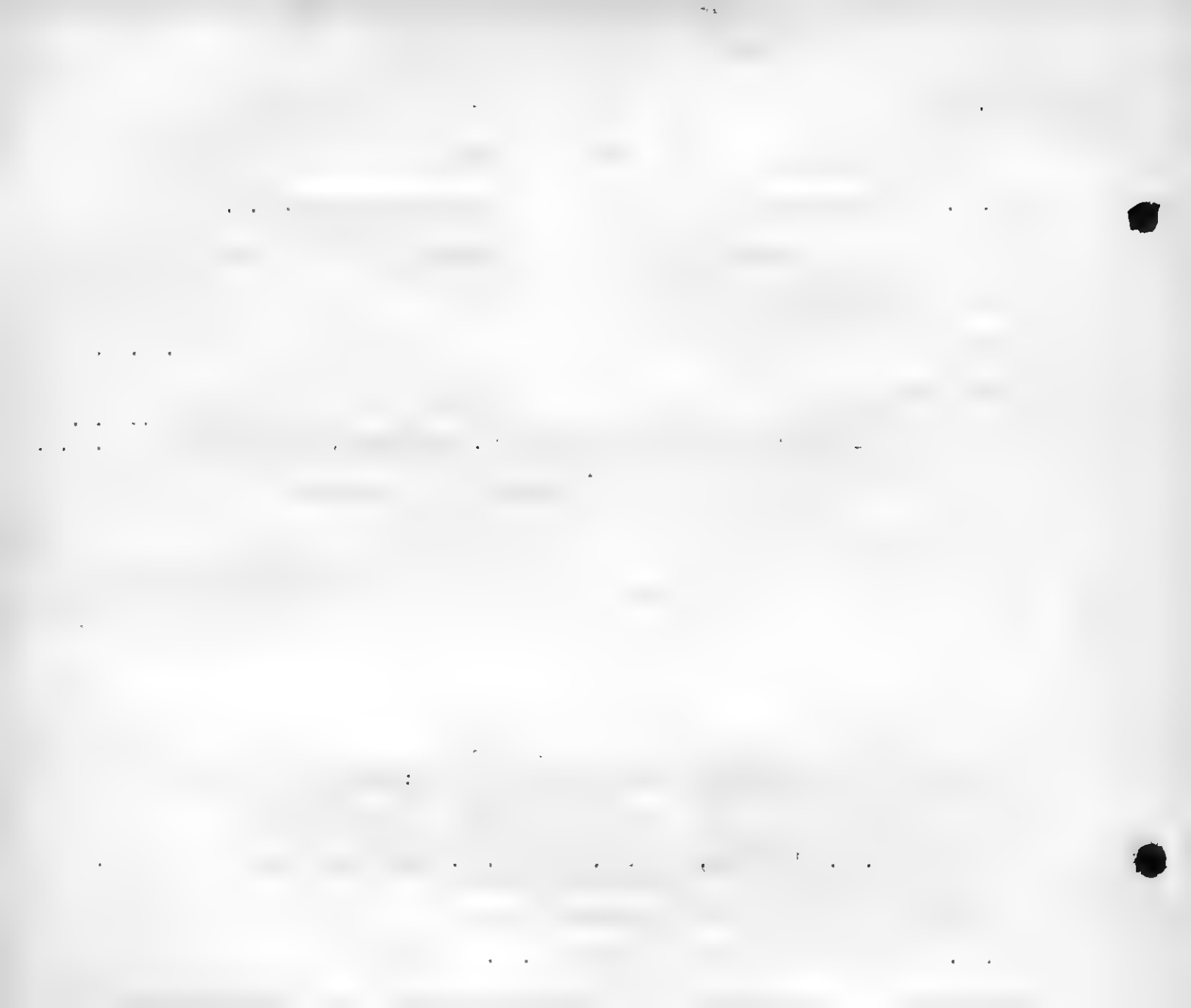


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7106 **CERTIFICATE OF DEATH**

07028

1. PLACE OF DEATH a. COUNTY Montgomery b. STATE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 143 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 804 Madison Avenue, N.W.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILLIAM Middle "C" Last COBBS				4. DATE OF DEATH Month June Day 18 Year 19 60			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-29-12	
9. AGE (In years last birthday) 48 yrs		IF UNDER 1 YEAR Months 4 Days 21		IF UNDER 24 HRS Hours Min 		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor	
10b. KIND OF BUSINESS OR INDUSTRY South Carolina				11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Wade COBBS				14. MOTHER'S MAIDEN NAME Essie LONG			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO World War II 579-09-7683		17. INFORMANT Address Wash., D.C. (W) Mrs. Maud Cobbs, 735 New Jersey Ave., N.W.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Hodgekin Disease (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from January 27, 1960 to June 18, 1960 , that (X) (we) last saw the deceased alive on 18 June 1960 , and that death occurred at 1:00 PM from the causes and on the date stated above.							
22a. SIGNATURE F. H. O'Connell M.D.				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) F. H. O'CONNELL, LCDR, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-23-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE W. E. Jarvis Funeral Home, Washington, D. C.				25a. REC'D BY REGISTRAR JUN 21 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hanes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

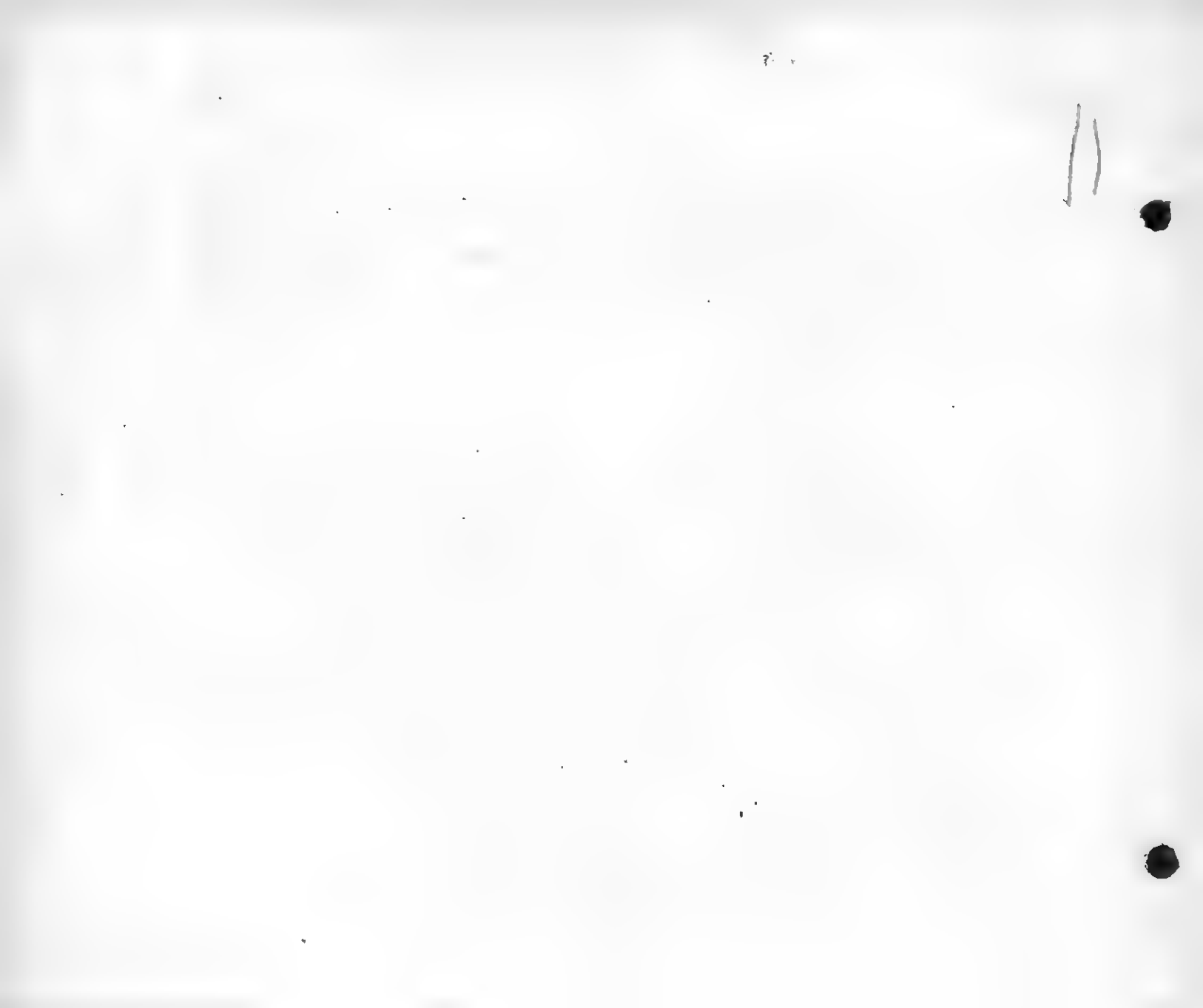


7107 CERTIFICATE OF DEATH

Reg. Dist. No. 07021

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MD. b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 11 Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 5923 Vandergrift Ave	
3. NAME OF DECEASED (Type or print) First Middle Last Infant Girl Colie		4. DATE OF DEATH Month Day Year June 6 19 60	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1960
9. AGE (In years last birthday) yrs. 8		10. IF UNDER 1 YEAR Months Days 8 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Bethesda, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Colie		14. MOTHER'S MAIDEN NAME Margaret Arnold	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO --	
INFORMANT Father Edward Colie		Address 5923 Vandergrift Ave. Rockville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fetal Alelectosis DUE TO (b) Prematurity DUE TO (c) 8 hours Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 8 hours		INTERVAL BETWEEN ONSET AND DEATH 8 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED When of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-6-60 to 6-6-60 , that I last saw the deceased alive on 6-6-60 , and that death occurred at 11:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Suburban Hospital 8600 Old Georgetown Rd Bethesda, Md. DATE SIGNED June 14 '60			
ACTUAL SIGNATURE J. W. Pearlman M.D.		PHYSICIAN'S NAME (Type) Suburban Hospital 8600 Old Georgetown Rd Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 6-9-60	
22c. NAME OF CEMETERY OR CREMATORY Suburban Hospital		22d. LOCATION (City, town, or county) (State) 8600 Old Georgetown Rd Bethesda, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Suburban Hospital 8600 Old Georgetown Rd Bethesda, Md.		24a. REC'D BY REGISTRAR June 14 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Anna		24c. REGISTRAR'S NAME (Type) Arthur S. Anna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician to the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7108

CERTIFICATE OF DEATH

07050

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN TB 2 hrs. 20 min. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Virginia b. COUNTY Alexandria c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3742 Keller Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Thomas William COLLINS		4. DATE OF DEATH Month Day Year June 15 19 60	
5 SEX Male	6 COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12-6-18 1916
9. AGE (In years and birthday) 43 1/2 yrs		10. UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps	
11 BIRTHPLACE (State or foreign country) Washington, D. C.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William COLLINS		14 MOTHER'S MAIDEN NAME Katherine SHEAHAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes 1942 to DOD		16 SOCIAL SECURITY NO. 579-24-0263	
17 INFORMANT (W) Mrs. Margaret Collins, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 Ventricular Fibrillation DUE TO myocardial infarct Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Thrombosis DUE TO (c) Coronary atherosclerosis INTERVAL BETWEEN ONSET AND DEATH 5 minutes 3 hours 3 hours systemic +			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from June 15 19 60 to June 15 19 60 , that (I) (the hospital) saw the deceased alive on June 15 19 60 , and that death occurred at 8P M, from the causes and on the date stated above			
22a. SIGNATURE F. H. O'Connell		22b. DATE SIGNED 6-16-60	
22c. PHYSICIAN'S NAME (Type) F. H. O'CONNELL, LCDR, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-20-60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City, town, or county) (State) Arlington Va.	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers & Co., 1400 Chapin St., NW, WashDC		25a. REC'D BY REGISTRAR JUN 20 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. House			



1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any fee is necessary, pay it to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY Montgomery **MARYLAND**
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN 1b 3 Weeks
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium & Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Virginia
b. COUNTY Fairfax
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fairfax
d. STREET ADDRESS 7 Colony Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First Frank Middle Chris Last Collis

4. DATE OF DEATH
Month June Day 4 Year 1960

5. SEX M
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Sept 5, 1919
9. AGE (In years last birthday) 40 yrs. IF UNDER 1 YEAR Months 4 Days 4 IF UNDER 24 HRS Hours 1 Min. 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Window Decorator
10b. KIND OF BUSINESS OR INDUSTRY Hospital Records
11. BIRTHPLACE (State or foreign country) Kentucky
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Chris Collis
14. MOTHER'S MAIDEN NAME Leona Dishman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
16. SOCIAL SECURITY NO. _____
17. INFORMANT Hospital Records Address _____

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Embolism
DUE TO Fracture Right Leg
CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last. _____
DUE TO _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) _____
INTERVAL BETWEEN ONSET AND DEATH 6Hrs
3Weeks

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from stepladder

20c. TIME OF INJURY Month, Day, Year 12 Noon 5/15 19 60
Hour _____ m. _____
20d. INJURY OCCURRED While ☒ at work Not While ☐ at work ☐ **20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) Embassy Men's Wear Wash. D. C.
20f. (City or town) Wash. D. C. (County) _____ (State) _____

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Broschart **EXAMINER'S NAME** (Type) Frank J. Broschart
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 6/7/60
22c. NAME OF CEMETERY OR CREMATORY National Memorial Park
22d. LOCATION (City, town, or country) Falls Church Va. (State) _____

23. FUNERAL DIRECTOR Harold W. Brandell **ADDRESS** Fairfax, Va.
24a. REC'D BY REGISTRAR Arthur E. Thomas
24b. REGISTRAR'S SIGNATURE _____
DATE JUN 8 '60



TO FURNISH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain in writing the reason therefor. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07952

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Potomac		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10017 Chapel Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Potomac	
3. NAME OF DECEASED (Type or print) First GORDON Middle F. Last COOPER		4. DATE OF DEATH Month June Day 10 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1903
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months 57 Days 57 Hours 57 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Telephone Co.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME George Cooper		14. MOTHER'S MAIDEN NAME Cora Fox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Yes-Unknown	
17. INFORMANT Wife		Address Mrs. Emily S. Cooper	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Found dead in Bed. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Found dead in Bed.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. BROSCHART		DATE SIGNED June 10, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-13-60	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Prince George Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE JUN 14 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7110

CERTIFICATE OF DEATH

07053

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 6 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY Co. GENERAL HOS PITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNIE Middle HARRISON Last COSTLEY		4. DATE OF DEATH Month JUNE Day 3 Year 1960	
5 SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ? 1878
9 AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM HARRISON		14. MOTHER'S MAIDEN NAME SALLY -- unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT HOSPITAL RECORDS		Address OLNEY, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO (b) Coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Pulmonary edema; Acute			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Peptic ulcer; stomach			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1959 to June 1960 that (I) (we) last saw the deceased alive on June 3, 1960 , and that death occurred 1:15 from the causes and on the date stated above.			
22a. SIGNATURE A. D. Bonifant		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) A. D. BONIFANT, M. D.		22d. ADDRESS SANDY SPRING, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-6-1960	
23c. NAME OF CEMETERY OR CREMATORY White Rock		23d. LOCATION (City, town, or county) (State) Carroll Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		25a. REC'D BY REGISTRAR DATE JUN 7 '60	
ADDRESS Winfield, Md.		25b. REGISTRAR'S SIGNATURE Charles S. French	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

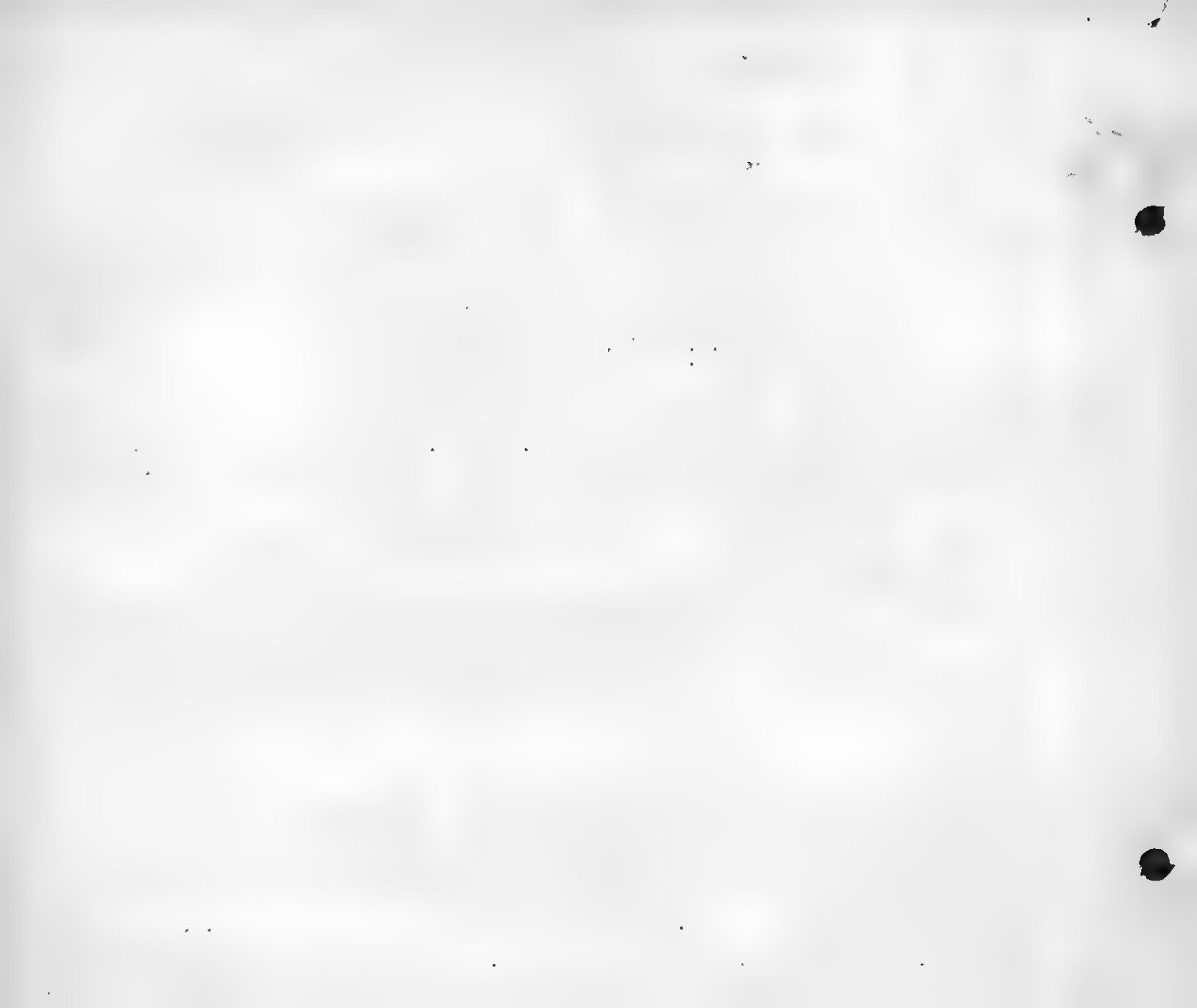
7026

CERTIFICATE OF DEATH

Reg. Dist. No.

0703

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 14 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9507 WARREN ST				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle C. Last Courbat				4. DATE OF DEATH Month JUNE Day 20 Year 19 60			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 4, 1890	
9. AGE (In years last birthday) yrs. 70		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman - Carpenter				10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't. Dept. of Interior		11. BIRTHPLACE (State or foreign country) SWITZERLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ALPHONSE COURBAT				14. MOTHER'S MAIDEN NAME ANNA CHEVILLAT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO 579-14-1491		17. INFORMANT Mrs. Nora M. Courbat, 9507 Warren St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 yrs 4 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Silver Spring, Md.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 1957 to 6-20-1960 , that I last saw the deceased alive on 6-10-1960 , and that death occurred at 5:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 915 19TH ST NW DATE SIGNED 6-20-60							
ACTUAL SIGNATURE Lewis H. Biben M.D.							
PHYSICIAN'S NAME (Type) LEWIS H. BIBEN MD WASHINGTON DC							
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/22/60		22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Jaska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE JUN 22 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hume			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07055

7111

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 15 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLARKSVILLE d. STREET ADDRESS 1-2 X e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALICE Middle -- Last CUFF 4. DATE OF DEATH Month JUNE Day 30 Year 19 60 5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 8/14/1890 9. AGE (In years last birthday) 69 yrs IF UNDER 1 YEAR Months Days Hours Min. 10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) SCOTLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A. 13. FATHER'S NAME THOMAS B. MCGREGOR 14. MOTHER'S MAIDEN NAME MARGARET BROWNE 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. None 17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CARDIAC FAILURE DUE TO CORONARY THROMBOSIS DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from JUNE 17, 19 60 to JUNE 30, 19 60 that (I) (we) last saw the deceased alive on JUNE 30, 19 60 and that death occurred at 12 M, from the causes and on the date stated above. 22a. SIGNATURE <i>C. S. Whitaker</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 7/1/60 22c. PHYSICIAN'S NAME (Type) C. S. WHITAKER, M. D. 22d. ADDRESS CLARKSVILLE, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town, or county) (State) Burial July 2 1960 Woodside Brinklow Md. 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>Francis H. Barber</i> Laytonsville, Md. DATE JUL 5 '60 <i>Arthur S. Hines</i>							

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove capers, papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

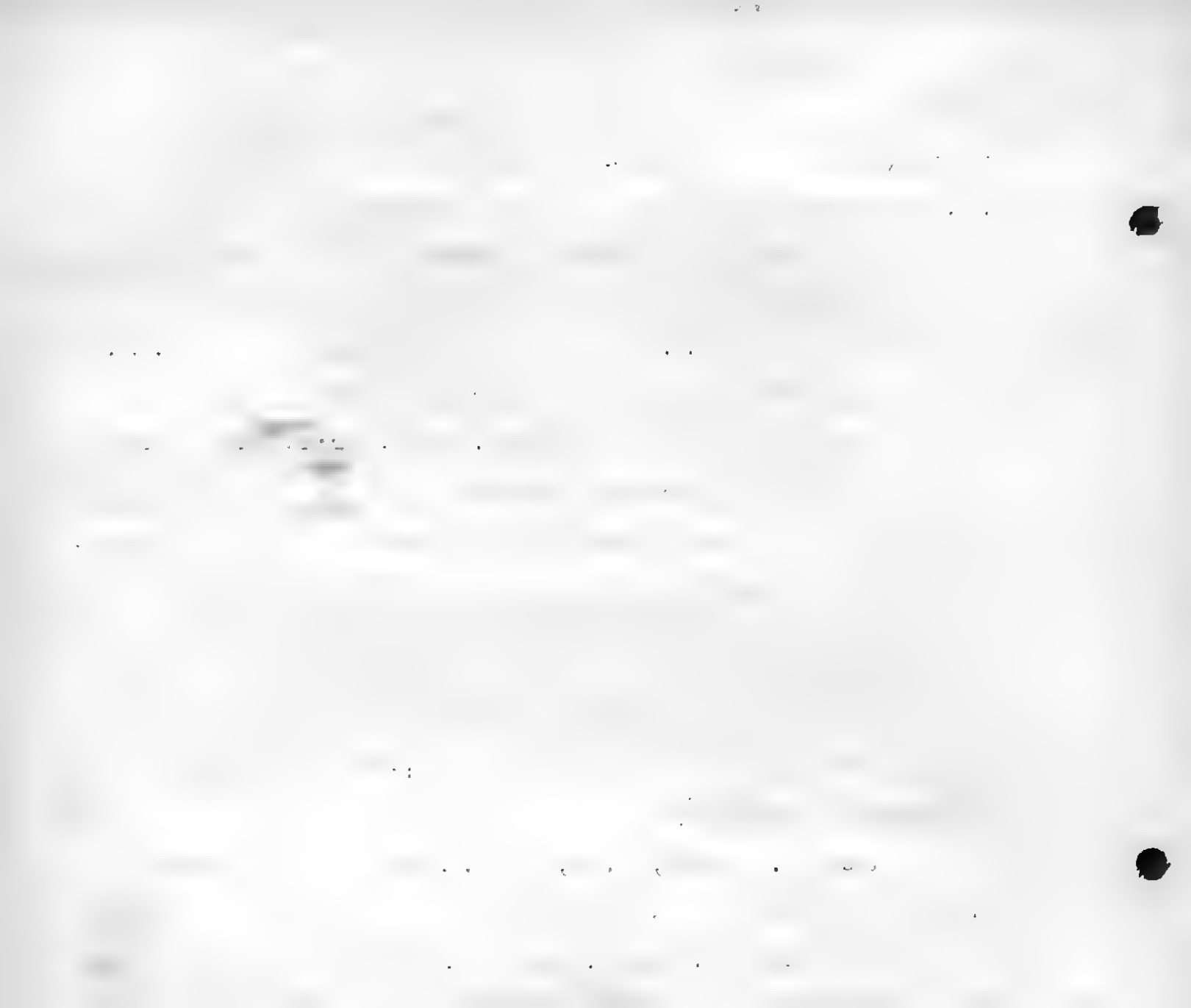
CERTIFICATE OF DEATH

7112

07050

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairfax	
c. LENGTH OF STAY IN 1b 40 min.		d. STREET ADDRESS Rt. 5, Box 310	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Paul Middle Michael Last CURRAN		4. DATE OF DEATH Month June Day 3 Year 1960	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-4-02
9. AGE (In years last birthday) 58 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S.Navy	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Joseph CURRAN		14. MOTHER'S MAIDEN NAME Mary Agnes FOLEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes 1921-1955		16. SOCIAL SECURITY NO. (W) Mrs. Mary V. Curran, same as #28 above	
17. INFORMANT (W) Mrs. Mary V. Curran, same as #28 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Infarction, myocardium 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hour 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) physician attended the deceased from June 3 1960 to June 3 1960 , that (I) xx last saw the deceased alive on June 3 1960 , and that death occurred at 11:25 PM , from the causes and on the date stated above.			
22a. SIGNATURE <i>Joseph E. Stitches</i>		22b. DATE 6-4-60	
22c. PHYSICIAN'S NAME (Type) Joseph E. STITCHER, LT, MC, USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 6/7/60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Everly Funeral Home</i>		25a. REC'D BY REGISTRAR JUN 7 '60	
25b. REGISTRAR'S SIGNATURE <i>Charles S. Rouse</i>		25c. ADDRESS EVERLY FUNERAL HOME 214 W. MAIN ST. FAIRFAX VA.	

MEDICAL CERTIFICATION



7078

7078

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>5 1/2 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens SAN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>HALE</u> Last <u>DARBY</u>		4. DATE OF DEATH Month <u>6</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-19-04</u>
9. AGE (In years lost birthday) <u>55</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ARCHITECT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. R. Darby</u>		14. MOTHER'S MAIDEN NAME <u>CLARE HALE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-14-5578</u>	
17. INFORMANT Address <u>Elinor R. Darby-wife-same as 2d</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarct</u> <u>4:30 P.M.</u> DUE TO <u>Coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-----</u> DUE TO <u>-----</u> (c) <u>-----</u> DUE TO <u>-----</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4-5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-----</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>-----</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/21/60</u> to <u>6/24/60</u> , that (I) (we) last saw the deceased alive on <u>5/21/60</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Manfred Steiner</u> M.D.		22b. DATE SIGNED <u>June 24 60</u>	
22c. PHYSICIAN'S NAME (Type) <u>MANFRED STEINER</u>		22d. ADDRESS <u>2300 K ST. N.W. WASH. DC</u>	
23a. BURIAL, CREMATION, or MOV. (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/27/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>June 28 1960</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

57

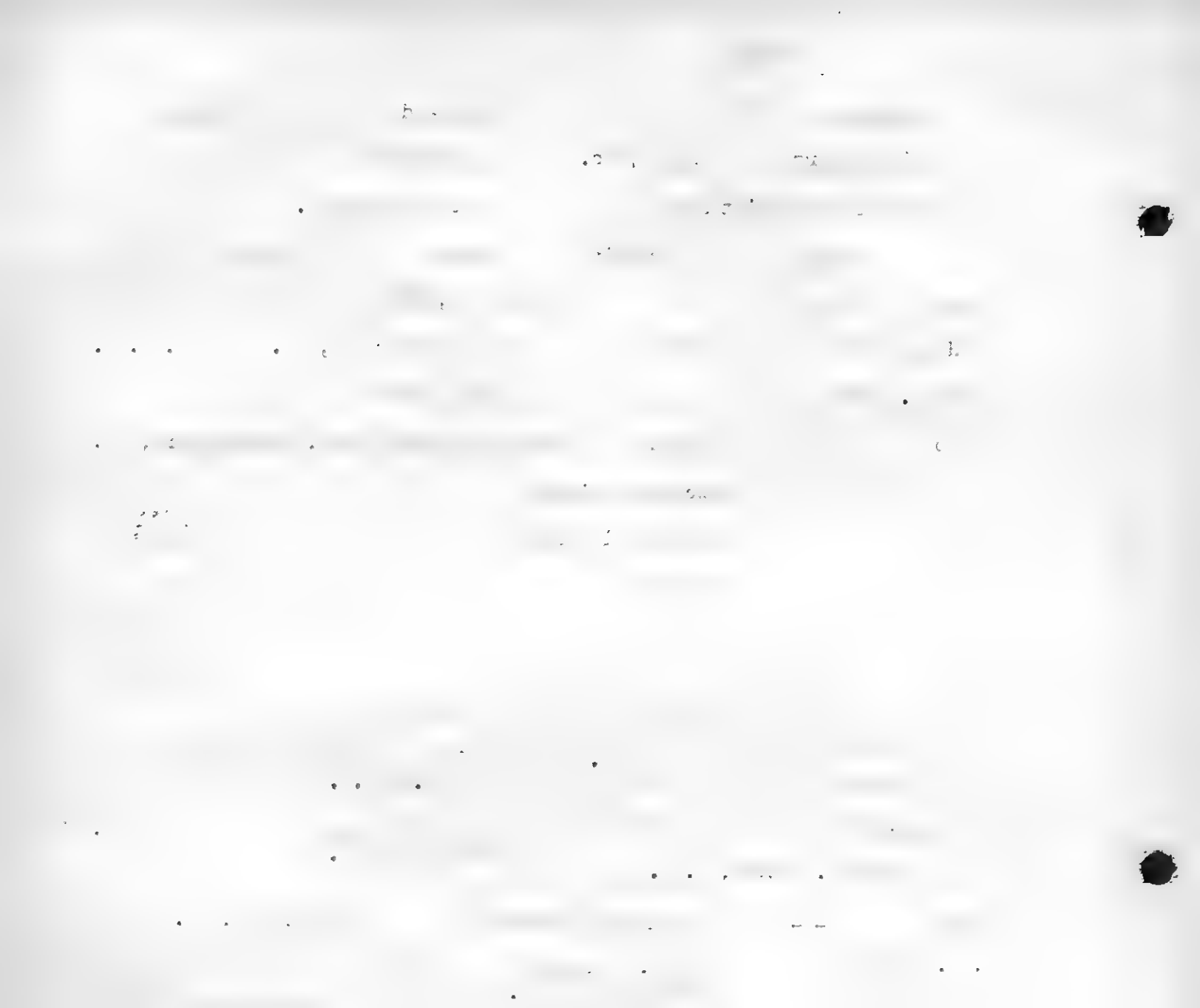
7073

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Asbury Methodist Home		d. STREET ADDRESS 516 Marietta St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Carrie Virginia Dawson		4. DATE OF DEATH Month Day Year June 3 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1867
9. AGE (In years lost birthday) 93 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Near Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Eli W. Dawson		14. MOTHER'S MAIDEN NAME Lucy Jacobs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO None	
17. INFORMANT Address Asbury Methodist Home, Gaithersburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Auricular fibrillation DUE TO (c) Pneumonia			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 13 , 19 57 to June 3 , 1960, that I last saw the deceased alive on June 1 , 19 60 , and that death occurred at 4.10 P.M. , the causes and on the date stated above. ADDRESS (Street, city or town, state) 10128 Cedar Land Kensington, Md. DATE SIGNED June 3, 1960			
ACTUAL SIGNATURE Sarah E. Glover		M.D. 10128 Cedar Land Kensington, Md.	
PHYSICIAN'S NAME (Type) Sarah E. Glover, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-6-60	22c. NAME OF CEMETERY OR CREMATORY Ros Hill Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE E. C. Gartner		ADDRESS 316 E. Diamond Gaithersburg, Md.	
24a. REC'D BY REGISTRAR DATE JUN 6 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7113

CERTIFICATE OF DEATH

0703

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived) If institution Residence before admission a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Blacksburg</u> <u>HA</u>	
c. LENGTH OF STAY IN 1b <u>1 yr 2 mo</u>		d. STREET ADDRESS <u>Blacksburg Rd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Broadway Foundation</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James E. Dent</u> First Middle Last		4. DATE OF DEATH <u>June 28</u> 1960 Month Day Year	
5. SEX <u>Male</u>	6. COLOR OF RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 25, 1950</u>
9. AGE (In years last birthday) <u>80</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>tenant farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James E. Dent</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Fossey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>4-12-12-12</u>	
17. INFORMANT <u>Edward J. Dent</u> Address <u>Blacksburg Rd</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO (b) <u>chronic arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>with a small</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> to <u>June 28, 1960</u> , that I last saw the deceased alive on <u>June 28, 1960</u> , and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. W. Malin</u> M.D.		ADDRESS (Street, city or town, state) <u>Blacksburg Rd</u> DATE SIGNED <u>June 28, 1960</u>	
PHYSICIAN'S NAME (Type) <u>L. W. Malin, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 30, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St John's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Beltsville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert J. Smith</u> ADDRESS <u>North 37th</u>		24a. REC'D BY REGISTRAR <u>Jul 5 '60</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hunt</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

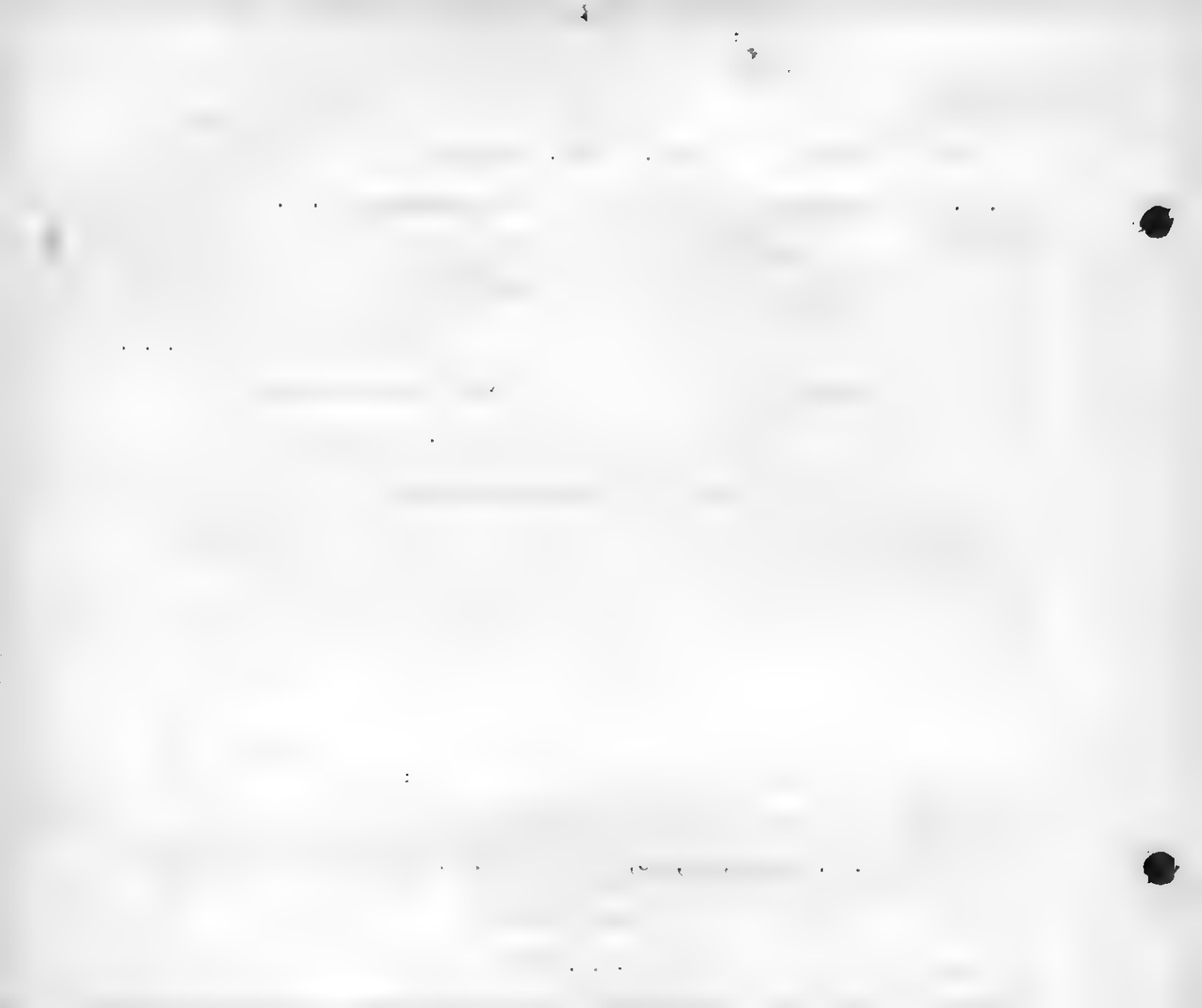
VR AIS (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7114
CERTIFICATE OF DEATH

07040

1. PLACE OF DEATH a. COUNTY Montgomery b. STATE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 8hrs. 49 min.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 1 Rudder Green, S. W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Girl Middle DISQUE Last		4. DATE OF DEATH Month June Day 12 Year 19 60	
5. SEX Female		6. COLOR OR RACE Caucasian	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-11-60	
9. AGE (in years lost birthday) yrs. 8		10. IF UNDER 1 YEAR Months 0 Days 0	
11. IF UNDER 24 HRS Hours 8 Min. 49		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Howard Olin DISQUE	
14. MOTHER'S MAIDEN NAME BeVerly Carole SEBRING		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO None		17. INFORMANT Address (F) Howard O. Disque, same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Defect of diaphragm, congenital DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 11 19 60 to June 12 19 60 that (I) (we) last saw the deceased alive on June 12 19 60 , and that death occurred at 2:52 from the causes and on the date stated above			
22a. SIGNATURE H. L. Walton M.D.		22b. DATE SIGNED 6-13-60	
22c. PHYSICIAN'S NAME (Type) H. L. WALTON, LT, MS, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 6-14-60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Mattingly Funeral Home, 131 11th St. S.E., WashDC		25a. REC'D BY REGISTRAR DATE JUN 14 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Kears			

2.9. Mattingly 660 20511 XV3



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7079

CERTIFICATE OF DEATH

07041

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. LENGTH OF STAY IN 1b Brookdale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium				d. STREET ADDRESS 4608 Overbrook Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) First HUGO Middle L Last DOERR				4. DATE OF DEATH Month June Day 28 Year 1960			
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11/29/1877	9 AGE (In years last birthday) 82 yrs	IF UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY School Teacher		11 BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Luckel				14. MOTHER'S MAIDEN NAME Margaret Roder			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT Col. Paul L. Doerr		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis, multiple DUE TO Cerebral arteriosclerosis, advanced DUE TO Arteriosclerosis generalised Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						INTERVAL BETWEEN ONSET AND DEATH 2 days 5 yrs + 5 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aphasia, global, old, due to old cerebral thrombosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21 I certify that (I) (this hospital) attended the deceased from July 1959 to June 27, 1960 , that (I) (we) last saw the deceased alive on June 23, 1960 , and that death occurred at 20 PM, from the causes and on the date stated above.							
22a. SIGNATURE Stewart Clapp M.D.				22b. DATE SIGNED 6/28/60			
22c. PHYSICIAN'S NAME (Type) Stewart Clapp				22d. ADDRESS 3921 Ingomar St NW Wash DC			
23a. BURIAL CREMATION. (Specify) BURIAL		23b. DATE THEREOF July 1, 1960		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town, or county) (State) Suitland Md	
24. FUNERAL DIRECTOR'S SIGNATURE John Carter's Son				25a. REC'D BY REGISTRAR ANN 29'60		25b. REGISTRAR'S SIGNATURE Orlino S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7115 CERTIFICATE OF DEATH

07042

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE New York b. COUNTY <input checked="" type="checkbox"/>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 20 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 516 East 13th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Antorino Middle (None) Last Dovi				4. DATE OF DEATH Month June Day 11 Year 1960				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 10, 1922		
9. AGE (In years last birthday) yrs. 31		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoemaker			10b. KIND OF BUSINESS OR INDUSTRY Shoe		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy <input checked="" type="checkbox"/>	
13. FATHER'S NAME Salvatore Dovi				14. MOTHER'S MAIDEN NAME Santa Azzolina				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Failure							Acute	
410X DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								
(b) Aortic Insufficiency							20 years	
DUE TO								
(c) Rheumatic Heart Disease							21 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Aortic Valvulotomy on Extracorporeal Circulation								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 22, 1960 to June 11, 1960 , that (I) (we) last saw the deceased alive on June 11, 1960 , and that death occurred at 1:20 PM from the causes and on the date stated above								
22a. SIGNATURE <i>Lazar Greenfield, M.D.</i>				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 6-12-60		
22c. PHYSICIAN'S NAME (Type) LAZAR GREENFIELD, M.D.				22d. ADDRESS The Clinical Center Bethesda 14 National Institutes of Health				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)		
Burial-transit		6/13/60		Unknown		New York City		
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert P. Pumpfun</i>				ADDRESS Bethesda, Md.		25a. REC'D BY REG. STRAR DATE JUN 20 1960		
						25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOST: OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07043

7027

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 11 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11803 Judson Rd.		d. STREET ADDRESS 11803 JUDSON ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last LAWRENCE DAVID DURRETTE, SR.		4. DATE OF DEATH Month Day Year JUNE 23, 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 4, 1930
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STAFF ASST.		10b. KIND OF BUSINESS OR INDUSTRY PHONE Co.	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH DIXON DURRETTE		14. MOTHER'S MAIDEN NAME FANNIE RHODES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES NAVY		16. SOCIAL SECURITY NO 290-12-4039	
17. INFORMANT MARIE E. DURRETTE, (SAME ADDRESS)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Heart-Disease (c) ESSENTIAL HYPERTENSION DUE TO DUE TO DUE TO SWIFE INTERVAL BETWEEN ONSET AND DEATH 6 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 7, 1951 to June 23, 1960 , that I last saw the deceased alive on June 23, 1960 , and that death occurred at 12:35 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Belden R. Reap M.D.		ADDRESS (Street, city or town, state) 11503 Franklin Ave	
PHYSICIAN'S NAME (Type) BELDEN R. REAP		DATE SIGNED 6/23/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JUNE 25, 1960	
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC.		24a. REC'D BY REGISTRAR DATE JUN 27 '60	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

3/

TO DEP. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form No. 3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7116

0794

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brinklow		c. LENGTH OF STAY IN 1b 1 yr.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS Brinklow	
3. NAME OF DECEASED (Type or print) Clarence Clinton Dyson		4. DATE OF DEATH June 29, 1960	
5. SEX male	6. COLOR OR RACE ool	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6/17/86
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	
11. IF UNDER 24 HRS. Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Dyson		14. MOTHER'S MAIDEN NAME Annie Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Nora Dyson		Address Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 54.4 DUE TO Acute congestive heart failure Conditions, if any, which gave rise to immediate cause (b) DUE TO Cardiac hypertrophy (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DATE THEREOF 7/2/60		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. NAME OF CEMETERY OR CREMATORY Pleasant View.	
22c. LOCATION (City, town, or country) (State) Quince Orchard, Md.		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR Robert L. Sunden		24a. REC'D BY REGISTRAR JUL 5 '60	
ADDRESS Rockville, Md.		24b. REGISTRAR'S SIGNATURE Robert L. Sunden	



Page 4 after death
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
M
1
2
1

7117

MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07045
07045

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>18 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		d. STREET ADDRESS <u>111 Southbrook Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Robert</u> Last <u>Edmonds</u>		4. DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 11, 1904</u>
9. AGE (In years last birthday) <u>55</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Superintendent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Concrete Products</u>	
11. BIRTHPLACE (State or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William F. Edmonds</u>		14. MOTHER'S MAIDEN NAME <u>Cora Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>577-10-4682</u>	
17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary congestion</u> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchogenic carcinoma</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>11 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 3, 1960</u> to <u>June 21, 1960</u> that (I) (we) last saw the deceased alive on <u>June 21, 1960</u> and that death occurred at <u>9:35 AM</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Charles E. Mengel M.D.</u>		22b. DATE SIGNED <u>6/21/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles E. Mengel, M.D.</u>		22d. ADDRESS <u>The Clinical Center, NIH Bethesda 14, Maryland</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/24/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. 2901 14th St., N.W.</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
ADDRESS <u>Wash. DC</u>		25b. REGISTRAR'S SIGNATURE	

146

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7113
CERTIFICATE OF DEATH

07046

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>82 days</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Carlisle</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>R.D. # 1</u>		e. RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Paul</u> Last <u>Eichhorn</u>				4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 19, 1950</u>		9. AGE (In years last birthday) <u>10</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Theodore F. Eichhorn</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Tarney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <u>None</u>		17. INFORMANT The Medical Record Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Disseminated aspergillosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute lymphocytic leukemia</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>3 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1960</u> Hour <u>0</u> m. <u>0</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 4</u> 19 <u>60</u> , to <u>June 25</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>June 25</u> 19 <u>60</u> and that death occurred at <u>7:40 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert A. Humphrey M.D.</u>				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>6/26/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT A. HUMPHREY, M.D.</u>				22d. ADDRESS <u>The Clinical Center NIH, Bethesda 14, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/29/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Cumberland Co. Penna.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>JUN 28 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

MEDICAL CERTIFICATION



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please return the remaining pages to the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

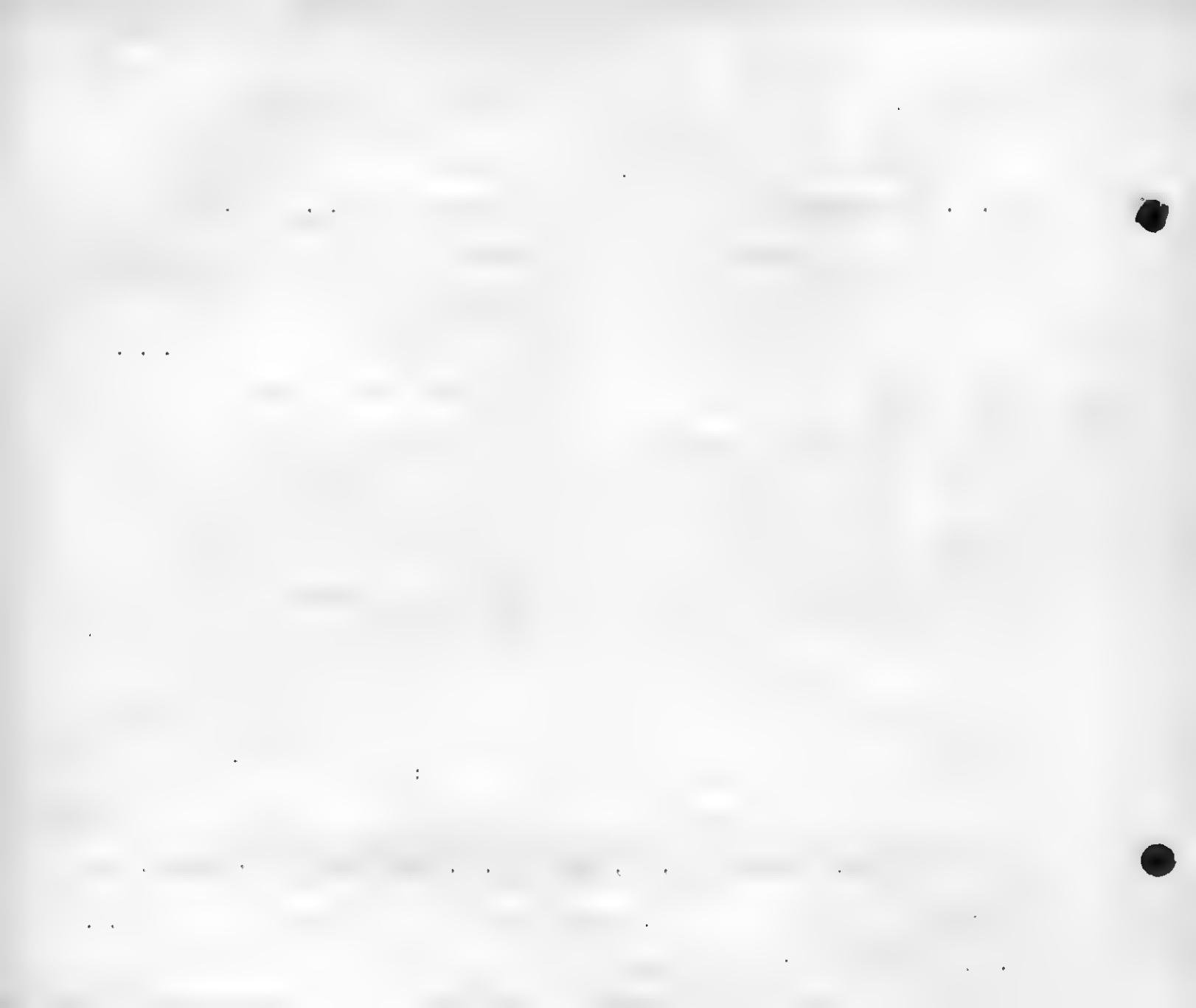
7119

CERTIFICATE OF DEATH

07047

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN TB 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 3866 9th St., S.E. - Apt. 302 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph (n) ERQUIZA		4. DATE OF DEATH Month Day Year June 21 1960	
5 SEX Male	6. COLOR OR RACE Malayan	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-19-60
9. AGE (In years lost birthday) yrs. 2		10. IF UNDER 1 YEAR: Months Days Hours Min 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jesus ERQUIZA		14. MOTHER'S MAIDEN NAME Ascension Vera BILLENA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congenital Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple Congenital Anomalies			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the undersigned) attended the deceased from June 19 1960 to June 21 1960 , that (I) (we) last saw the deceased alive on June 21 1960 , and that death occurred at 9:55 AM from the causes and on the date stated above.			
22a. SIGNATURE Fred W. Grello M.D.		22b. DATE 6-21-60	
22c. PHYSICIAN'S NAME (Type) Fred W. GRELLO, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-24-60	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Washington D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey ADDRESS Funeral Home, Bethesda, Md.		25a. REC'D BY REGISTRAR DATE JUN 24 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

2051275X4



TO DEPARTMENT OF HEALTH. This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

(M)

(1)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										07048	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg R-3</u>											
c. LENGTH OF STAY IN 1b <u>12 yrs</u>											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Longcroft Rd</u>											
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>											
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>											
d. STREET ADDRESS <u>Longcroft Rd</u>											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Oliver Virginia Estes</u>											
4. DATE OF DEATH <u>June 15 1960</u>											
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept 17-1919</u> 9. AGE (In years last birthday) <u>40</u> yrs. IF UNDER 1 YEAR: Months <u>6</u> Days <u>15</u> IF UNDER 24 HRS: Hours <u>15</u> Min. <u>00</u>											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>											
10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>											
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>											
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
13. FATHER'S NAME <u>John W. Rines</u>											
14. MOTHER'S MAIDEN NAME <u>Mary Abel</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of serv. ca.) <u>No</u>											
16. SOCIAL SECURITY NO. <u>229-36-1172</u>											
17. INFORMANT <u>Everett V. Estes Sr.</u> Address <u>Itan 2</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Sudden death in bed</u> (a), stating the underlying cause last. DUE TO (c) <u>in bed</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>6-15-60</u>											
Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>6/17/60</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Darnestown Church Cem</u> 22d. LOCATION (City, town, or country) (State) <u>Darnestown, Maryland</u>											
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u> 24a. REC'D BY REGISTRAR <u>JUN 16 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hous</u>											

X

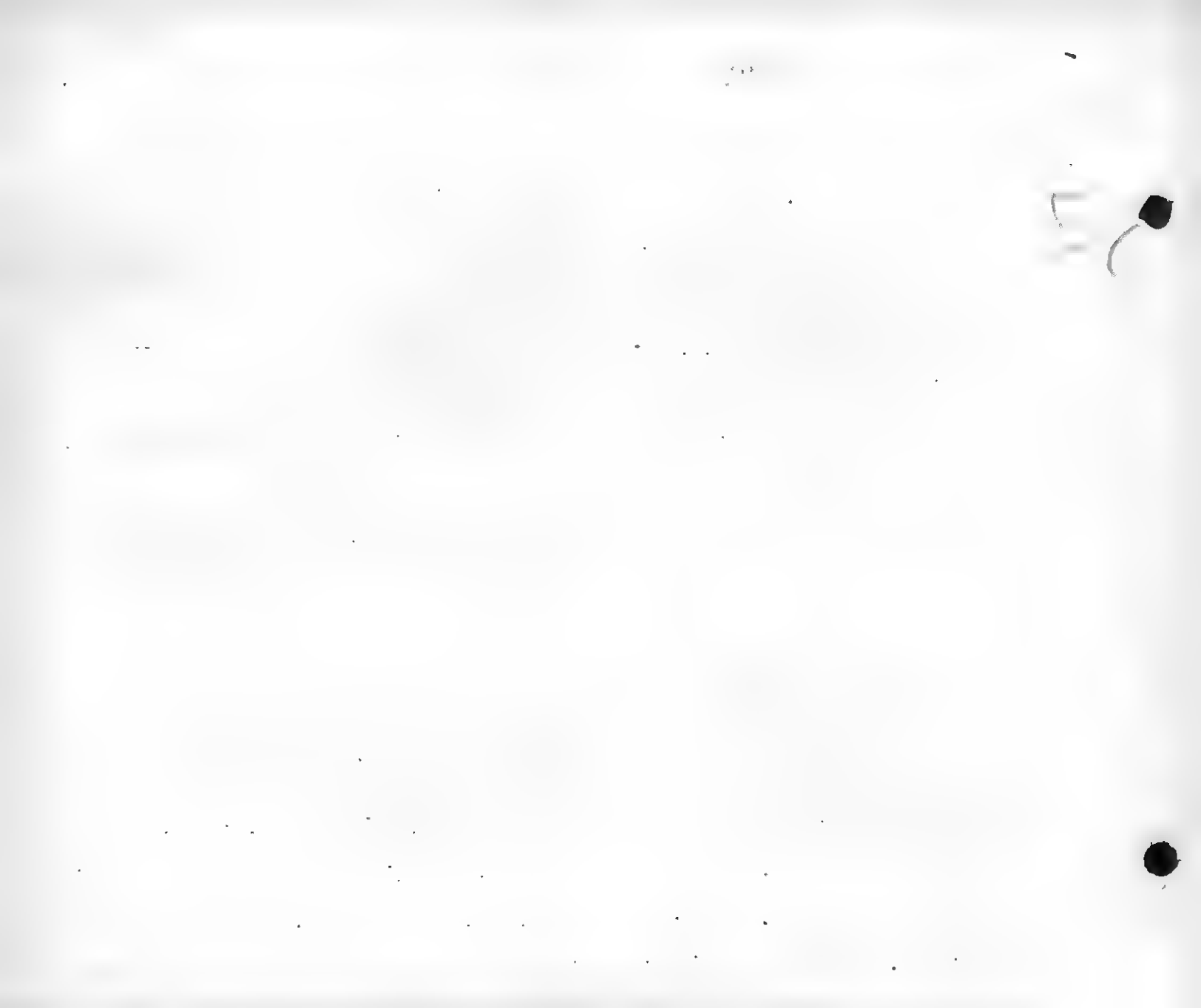
07049

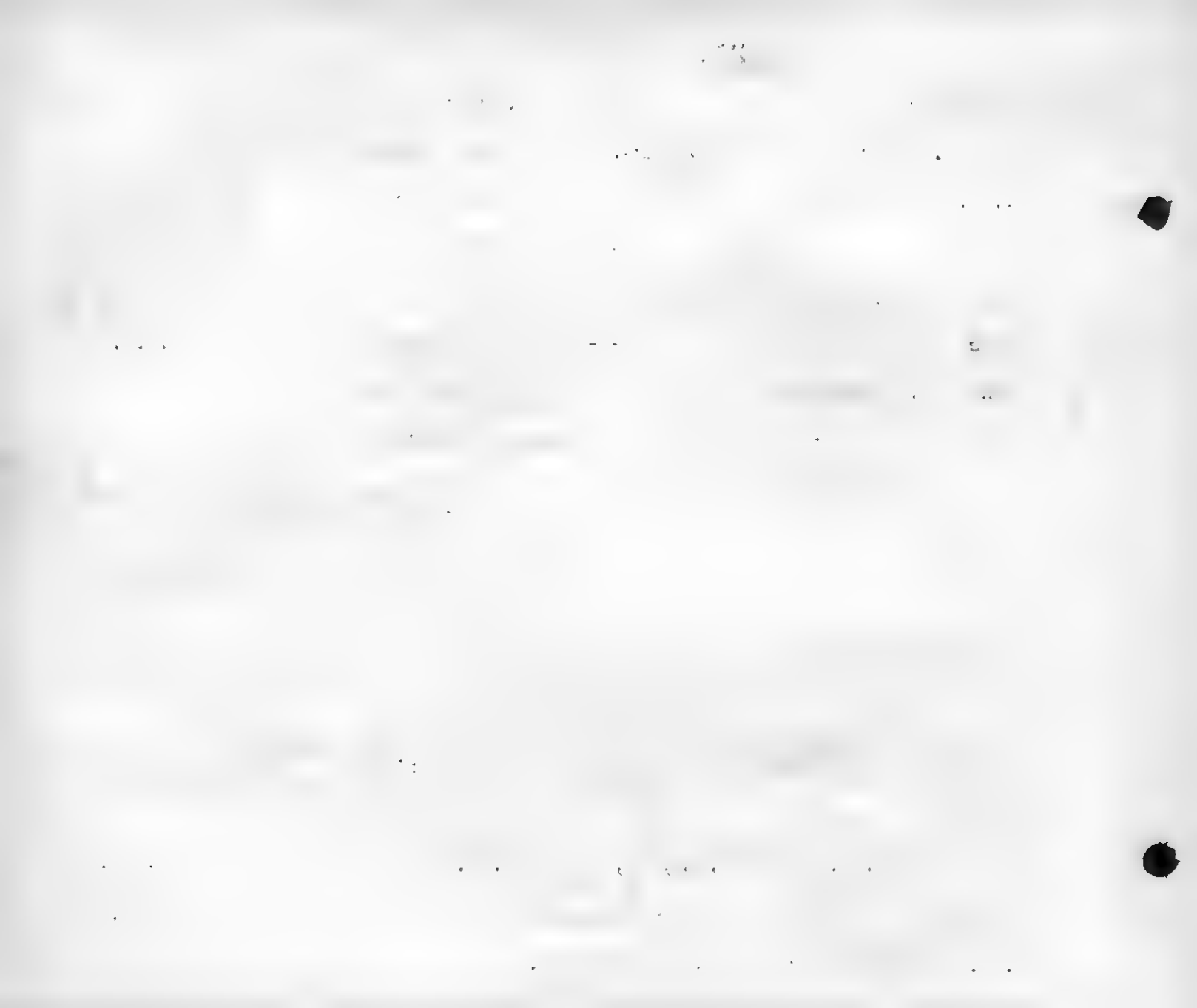
7121
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Res dence before admision) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>32 days 21 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>4723 River Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Eugene</u> First <u>R.</u> Middle <u>Fair</u> Last				4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>1960</u>			
5 SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/10/09</u>	
9 AGE (In years last birthday) <u>50</u> yrs		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min <u></u>		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Planning officer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Information Agency</u>		11. BIRTHPLACE (State or foreign country) <u>Kirksville, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Dr. Eugene Fair</u>				14. MOTHER'S MAIDEN NAME <u>Alta Lorenz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>472209673</u>			
INFORMANT Address <u>Mrs. Linda Fair Ratcliffe Apt. 1061 18th St. Arlington, Va.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic glomerular nephritis</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>marked coronary atherosclerosis & multiple myocardial infarcts</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 25, 1960</u> to <u>June 27, 1960</u> , that I last saw the deceased alive on <u>June 26, 1960</u> , and that death occurred at <u>6:22 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Alfred S. Norton</u>				ADDRESS (Street, city or town, state) <u>4711 Highland Ave. Beth. Md.</u> DATE SIGNED <u>6/27/60</u>			
PHYSICIAN'S NAME (Type) <u>Alfred S. Norton</u>				<u>4711 Highland Ave. Bethesda, Md.</u>			
22a. BURIAL, CREMATION, RE MOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Cremation</u>		<u>6/29/60</u>		<u>Cedar Hill Crematory</u>		<u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>JUN 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





7123

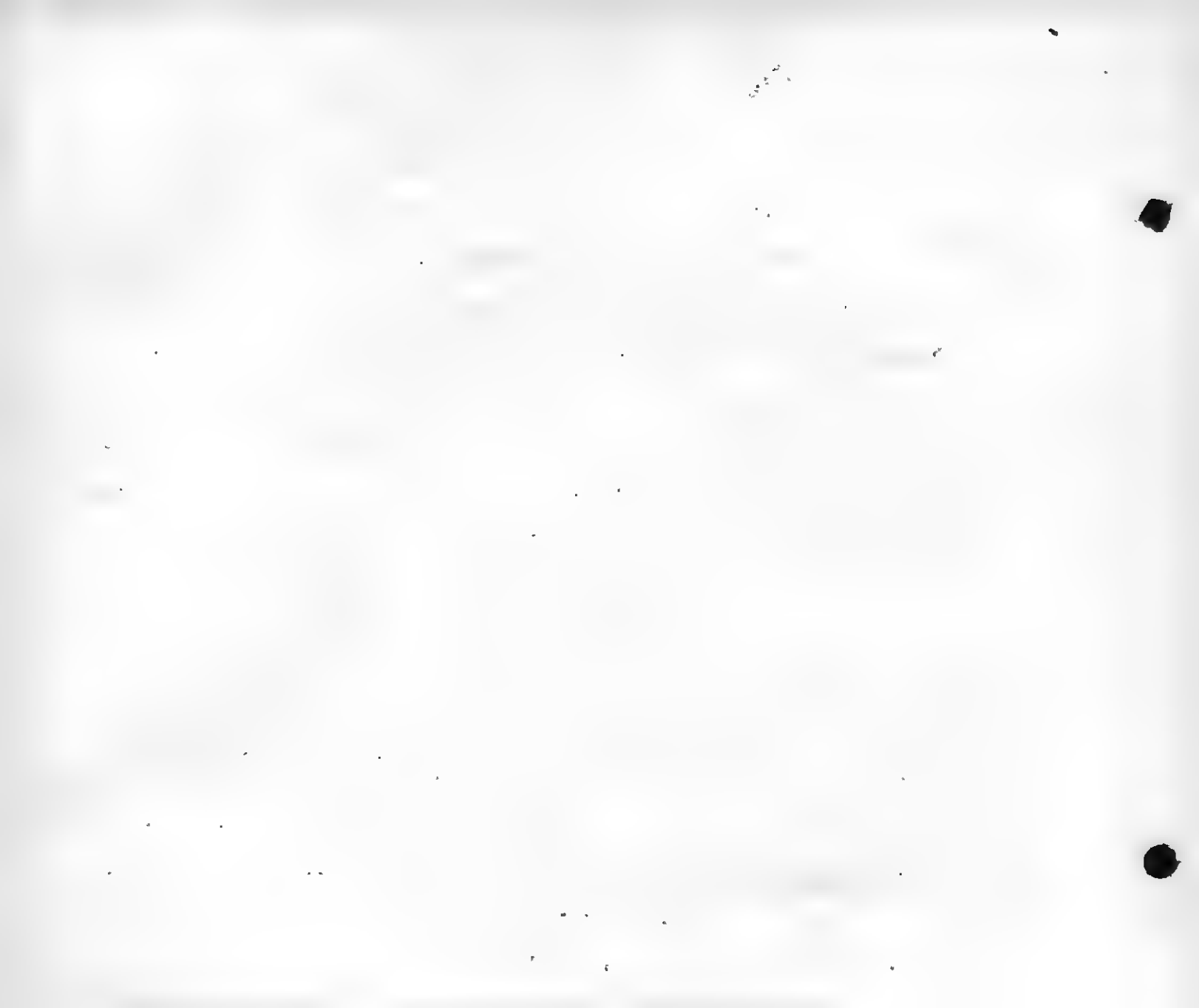
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 14 MRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS Hilltop Golf Lane							
3. NAME OF DECEASED (Type or print) James D. Ferguson Jr.				4. DATE OF DEATH Month June Day 17 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/22/15	9. AGE (In years last birthday) 45 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Consulting		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Du Bose Ferguson Sr.				14. MOTHER'S MAIDEN NAME Mathilde McIntire			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		INFORMANT Wife Kate S. Ferguson		Address Hilltop Golf Lane Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEPATIC FAILURE 5009 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Hepatic Necrosis, etiology indeterminate DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 days 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 6 , 19 55 , to June 17 , 19 60 , that I last saw the deceased alive on June 16 , 19 60 , and that death occurred at 5:19 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert G. Angle		ADDRESS (Street, city or town, state) 5009 DelRay Ave., Bethesda, Md. DATE SIGNED 4/17/60					
PHYSICIAN'S NAME (Type) Robert G. Angle		5009 DelRay Ave. Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL, (Specify) Burial		22b. DATE THEREOF 6/18/60		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUN 20 1960	
				24b. REGISTRAR'S SIGNATURE Arthur S. House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7124

CERTIFICATE OF DEATH

07052

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Tennessee b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Johnson City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS Route # 1, Greenwood Drive	
3. NAME OF DECEASED (Type or print) First Jack Middle Leon Last Fillers		4. DATE OF DEATH Month June Day 8 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5, 1934
9. AGE (In years lost birthday) yrs. 26		IF UNDER 1 YEAR Months 26 Days 26 Hours 26 Min. 26	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant		10b. KIND OF BUSINESS OR INDUSTRY Service Station	
11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Bruce Fillers		14. MOTHER'S MAIDEN NAME Bonnie McKinney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 411-48-3803	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hodgkins Disease DUE TO (c) Pneumonitis		INTERVAL BETWEEN ONSET AND DEATH 5 min 1 yr 1 wk	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 17, 1960 to June 8, 1960 , that (I) (we) last saw the deceased alive on June 8, 1960 , and that death occurred at 8:40 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Harold J. Fallon M. D.		22b. DATE 6/9/60	
22c. PHYSICIAN'S NAME (Type) Harold J. Fallon, M. D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-11-60	
23c. NAME OF CEMETERY OR CREMATORY MONTE-VISTA		23d. LOCATION (City, town, or county) (State) Johnson City, Tenn.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR June 13 '60	
ADDRESS Bethesda		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	



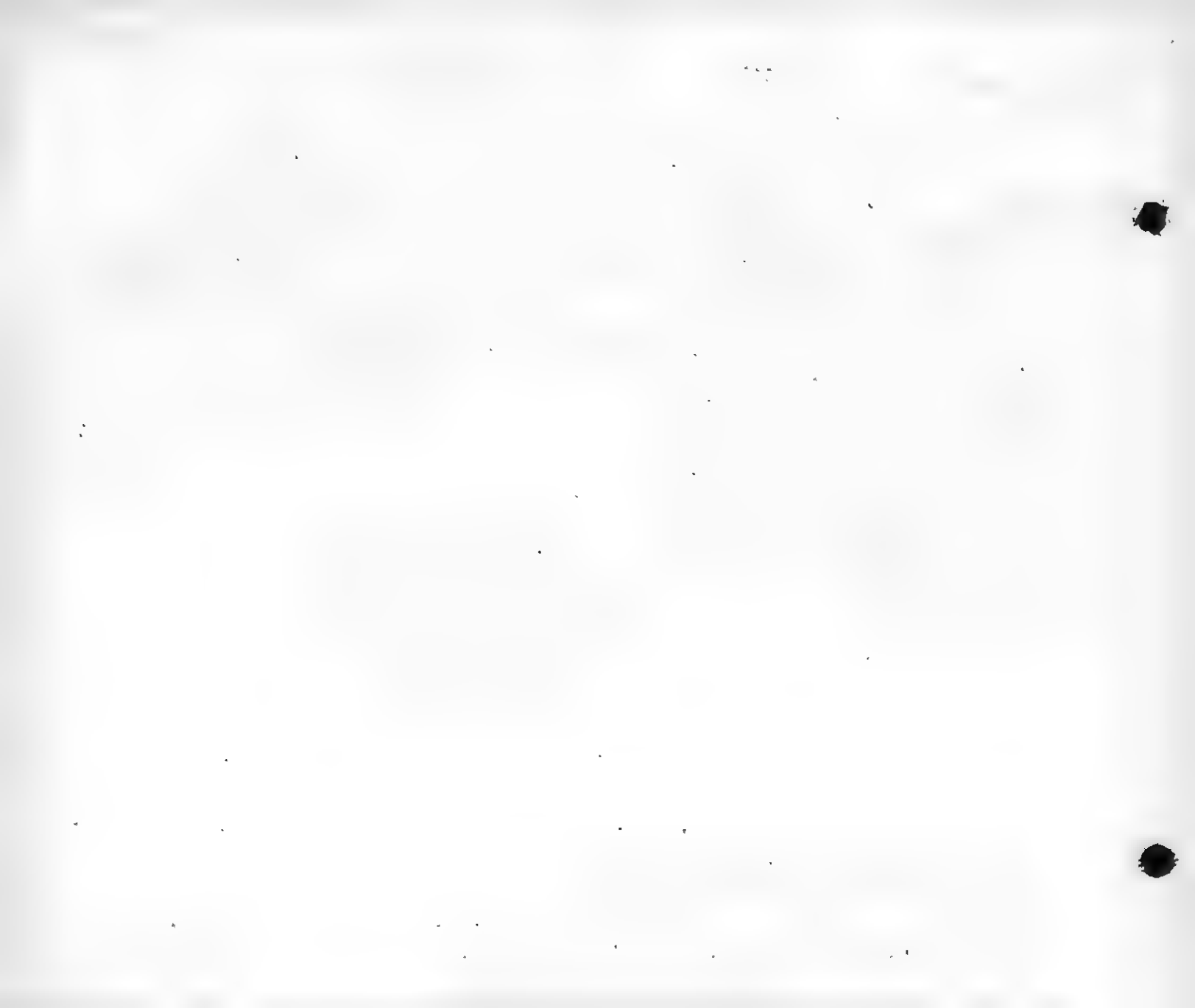
CERTIFICATE OF DEATH

Reg. Dist. No. 07053

7125

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban</u>				e. STREET ADDRESS <u>2611 - Finley St</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Elmer Fisher</u>				4. DATE OF DEATH Month Day Year <u>June 29 1960</u>			
5 SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 21 1914</u>	
9. AGE (In years last birthday) <u>45</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police man</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Washington Metropolitan Police</u>			
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James M. Fisher</u>				14. MOTHER'S MAIDEN NAME <u>Virginia. Estes.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO <u>YES</u>			
17. INFORMANT <u>Doris L. Fisher</u>				Address <u>5 June As above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.0</u> DUE TO <u>Cerebral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral</u> DUE TO <u>Pancreatitis Chronic</u> (c) <u>submen</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>12 month</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>2/1</u> 19 <u>57</u> to <u>6/29</u> 19 <u>60</u> that I last saw the deceased alive on <u>6/29</u> 19 <u>60</u> , and that death occurred at <u>6:15</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Rockville, Md</u> DATE SIGNED <u>6/29/60</u>							
ACTUAL SIGNATURE <u>Stephen N. Jones</u> M.D.				PHYSICIAN'S NAME (Type) <u>STEPHEN N. JONES</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/2/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Jaska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 6 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

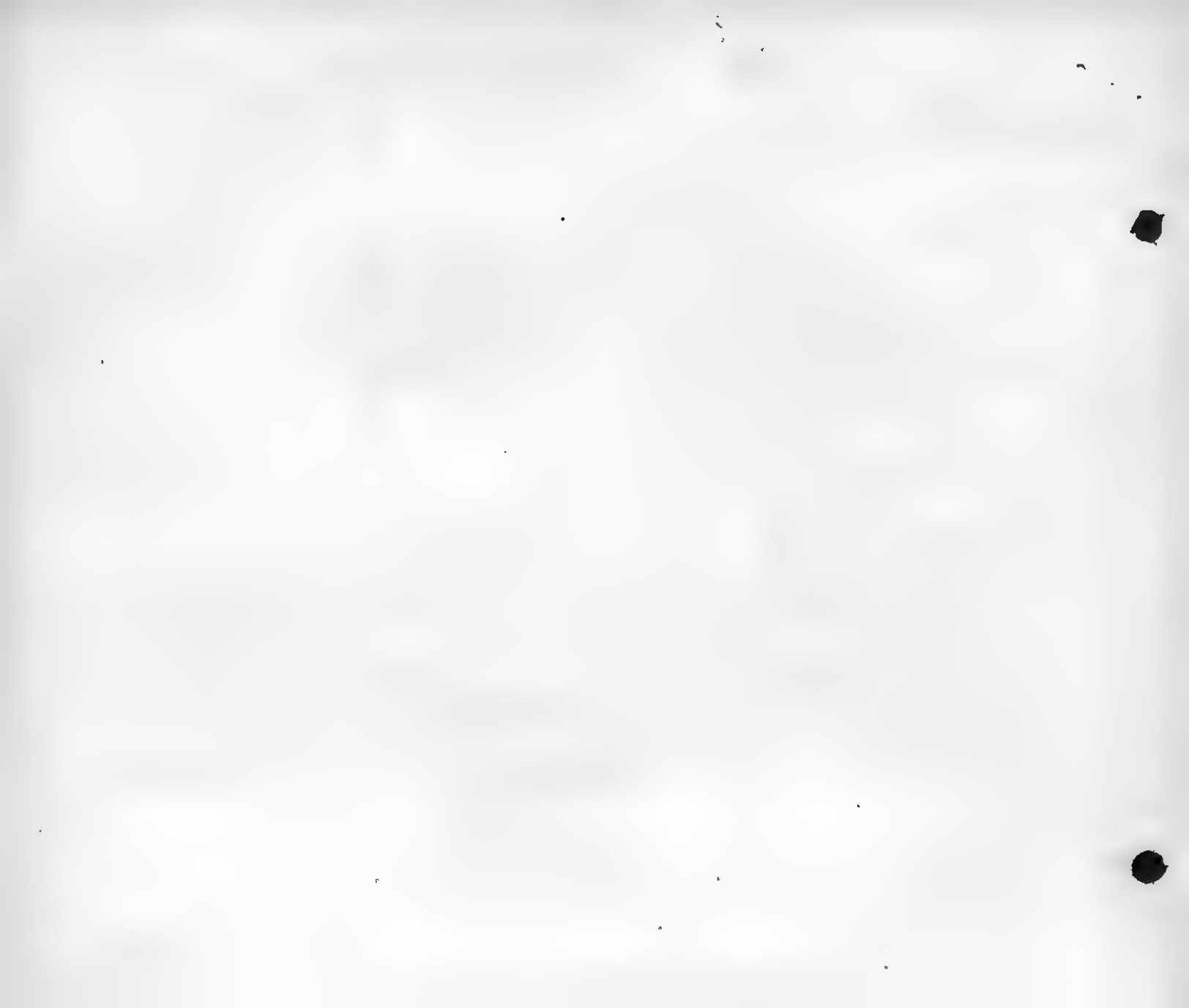
7126

CERTIFICATE OF DEATH

Reg. Dist. No.

07054

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maine b. COUNTY Kennebec	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY in 1b 74 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 18 Page Street	
3. NAME OF DECEASED (Type or print) First Hope Middle Gladys Last Fisher		4. DATE OF DEATH Month June Day 1 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10, 1902
9. AGE (In years last birthday) 57 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maine		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Holman Currier		14. MOTHER'S MAIDEN NAME Clara White	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO Unascertainable	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema and bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adrenal cortical carcinoma DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 5 days 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from March 19 , 19 60 , to June 1 , 19 60 , that I last saw the deceased alive on June 1 , 19 60 , and that death occurred at 11:20A M, from the causes and on the date stated above ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 6/1/60 ACTUAL SIGNATURE Saul Genuth M.D. National Institutes of Health PHYSICIAN'S NAME (Type) Saul Genuth, M.D. Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 6/5/60	
22c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		22d. LOCATION (City, town, or county) (State) Augusta, Maine	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE JUN 3 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	



7127

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Margaret R Flaherty				4. DATE OF DEATH Month Day Year June 6 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/29/1912	
9. AGE (In years lost birthday) 47 yrs.		10. IF UNDER 1 YEAR Months 10 Days 7 Hours Min. 		11. IF UNDER 24 HRS. Hours Min. 		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY Min. Minnesota			
13. FATHER'S NAME John				14. MOTHER'S MAIDEN NAME Annie Kirwin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Thomas F. Flaherty-husband-same 2d				Address 			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma-Generalized							
DUE TO (b) Cachexia							
DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from JUNE 4 19 58 to JUNE 6 19 60 that I last saw the deceased alive on MAY 27 19 60 , and that death occurred at 3 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Philip A. Caulfield M.D.				ADDRESS (Street, city or town, state) 8 W. Lenox St. Ch. Ch. Md.			
DATE SIGNED 6/6/60							
PHYSICIAN'S NAME (Type) Phillip A. Caulfield				8 W. Lenox St. Ch. Ch. Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/9/60		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		22d. LOCATION (City, town, or county) (State) Silver Spring, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland			
24a. REC'D BY REGISTRAR JUN 8 '60				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

47

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07056

Reg. Dist. No.

7128

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>6 Hrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Dallas Francis Flynn</u>				4. DATE OF DEATH Month Day Year <u>June 5 19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 6, 1877</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John Flynn</u>			14. MOTHER'S MAIDEN NAME <u>Eliza Hefflin</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Kathryn Lindgreen (Daughter)</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	Month, Day, Year <u>19 60</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brochart</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED	
EXAMINER'S NAME (Type) <u>Frank J. Brochart</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			<u>6-52-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 8, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fairfax</u>		22d. LOCATION (City, town, or county) <u>Fairfax, Virginia</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE By <u>Everly Funeral Home</u> Manager			ADDRESS <u>Fairfax, Virginia</u>		24a. REC'D BY REGISTRAR <u>June 8 '60</u>	24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other is necessary, please execute a separate certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

4-

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 12 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
7051 CERTIFICATE OF DEATH									
Reg. Dist. No. Q2057									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>					2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>37 Silver Spring</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>					d. STREET ADDRESS <u>2806 Ivydale</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Fowle</u>					4. DATE OF DEATH Month Day Year <u>June 18 1960</u>				
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-16-60</u>		9. AGE (In years last birthday) yrs <u>2</u> <u>9</u> <u>12</u>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Morgan Rene Fowle</u>					14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Meyers</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO		17. INFORMANT <u>mother</u>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interventricular septal defect</u> <u>Patent foramen ovale & Patent Ductus Arteriosus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>None</u> (c) <u>(Congenital Heart Disease)</u>								INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 hr, 12 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>6-16-60</u> to <u>6-17-60</u> , that I last saw the deceased alive on <u>6-17-60</u> , and that death occurred at <u>1:35 P.M.</u> from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Robert C. Warthen, M.D.</u>					ADDRESS (Street, city or town, state) <u>3716 ASHLAND AVE.</u> DATE SIGNED <u>6-17-60</u>				
PHYSICIAN'S NAME (Type) <u>Robert Warthen, M.D.</u>					<u>KEYS INC. MD.</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>6-22-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wash. San. Hosp</u>			22d. LOCATION (City, town, or county) (State) <u>Takoma Park Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Hare, M.D., Wash. San. & Hosp.</u>					24a. REC'D BY REGISTRAR DATE <u>JUN 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hare</u>		

VS A15 (4)
15M 10/57



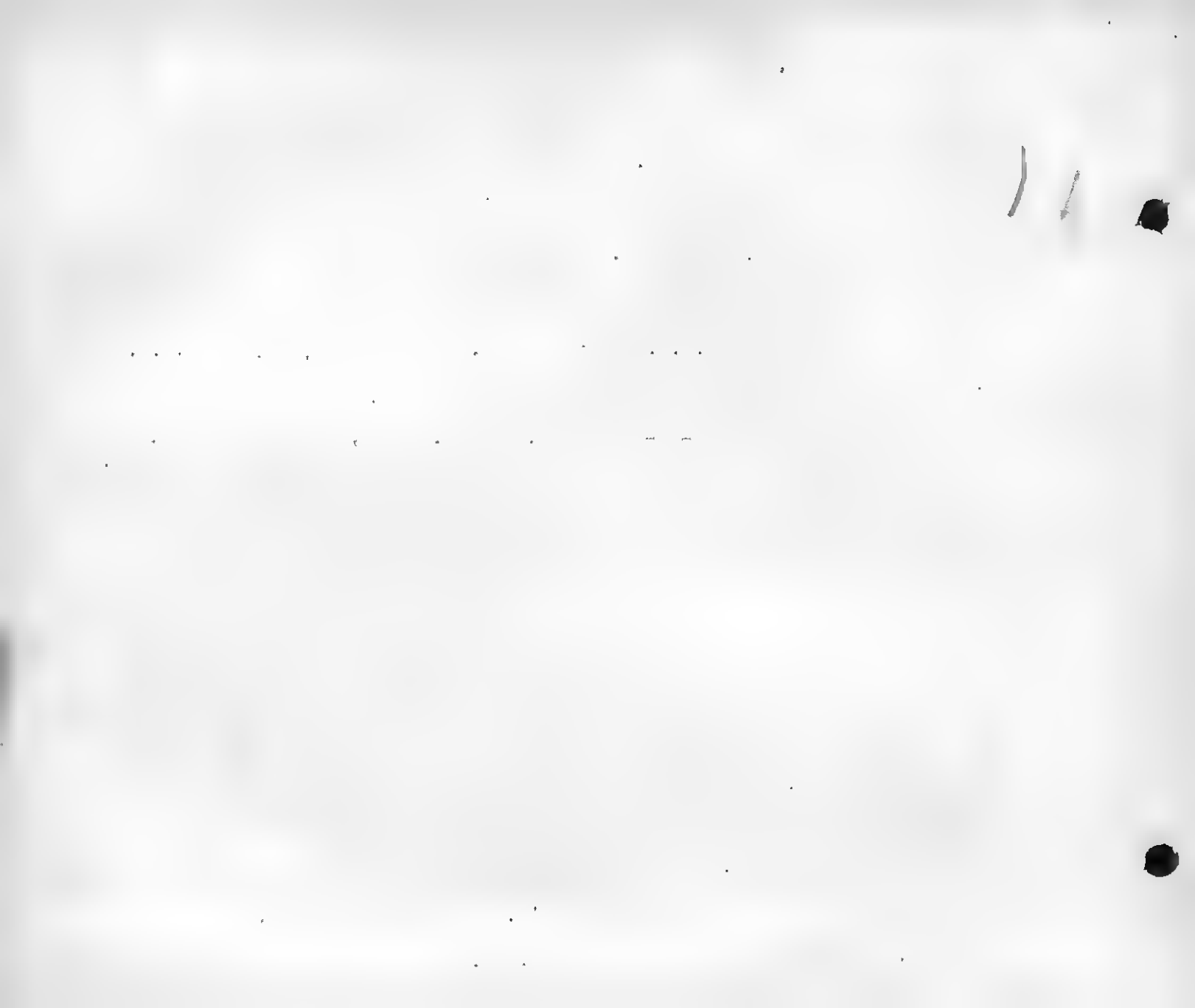
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

VR A15 (4)
TSM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7028 CERTIFICATE OF DEATH

07058

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 1 yr.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 SILVER SPRING		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9707 DILSTON ROAD	
d. STREET ADDRESS 9707 DILSTON ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First ALFONSO Middle S. Last FUSCO		4. DATE OF DEATH Month JUNE Day 1 Year 19 60	
5 SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/30/24
9. AGE (In years most birthday) 36 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EXAMINER		10b. KIND OF BUSINESS OR INDUSTRY U.S.C. Federal Gov't.	
11 BIRTHPLACE (State or foreign country) Washington, D.C.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Salvatore Fusco		14. MOTHER'S MAIDEN NAME Camilla XXXXXX De Nenna	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW #2 577-28-9036	
17. INFORMANT Mrs. Rita A. Fusco, 9707 Dilston Rd.		Address Silver Spring, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of the male breast tissue</u> DUE TO (c) <u>8 months</u> PART II. OTHER SIGNIFICANT CONTRIBUTING CAUSES CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> INTERVAL BETWEEN ONSET AND DEATH 3 days			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from April 1960 to June 1 1960 that (I) (we) last saw the deceased alive on June 1 1960 and that death occurred at 4:00 PM, from the causes and on the date stated above			
22a. SIGNATURE Ralph F. Patten		22b. DATE SIGNED 6/1/60	
22c. PHYSICIAN'S NAME (Type) RALPH F. PATTEN MD		22d. ADDRESS 8641 - Colasville Road Silver Spring, MD	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 6/5/60	
23c NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		23d LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
24 FUNERAL DIRECTOR'S SIGNATURE Raymond A. Zucka		25a REC'D BY REGISTRAR DATE JUN 9 '60	
ADDRESS SILVER SPRING, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	



may be used by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 42 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										07059	
7070											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) o STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. LENGTH OF STAY IN 1b 15 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4727 Essex Street Avenue						d. STREET ADDRESS 4727 Essex Street Ave.					
3. NAME OF DECEASED (Type or print) First Mary Middle M Last Gerig						4. DATE OF DEATH Month June Day 7 Year 19 60					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/13/98		9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 4 Days 28 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ohio			12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME ? Blosser						14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address O. Benjamin Gerig-Husband-same 2d							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Cardiac Distention 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Hypertension										INTERVAL BETWEEN ONSET AND DEATH 10-15 min	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 		(County) 		(State) 	
21. I certify that (I) (this hospital) attended the deceased from June 2, 1960 to June 7, 1960 , that (I) (we) last saw the deceased alive on June 7, 1960 , and that death occurred at 7:45 PM , from the causes and on the date stated above.											
22a. SIGNATURE W. B. Wardrop MD						M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 6/7/60			
22c. PHYSICIAN'S NAME (Type) W. B. WARDROP MD						22d. ADDRESS 800 PERSHING DRIVE SILVER SPRING					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/10/60		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town, or county) (State) Rockville, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey						ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DAVID N 10 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

35

7052

CERTIFICATE OF DEATH

07060

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. STREET ADDRESS <u>8701 Barron Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Karen</u> Middle <u>Ann</u> Last <u>GOFORTH</u>				4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1960</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 21, 1960</u>	
9. AGE (In years last birthday) yrs		IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>—</u> Min. <u>2</u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>baby</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>							
13. FATHER'S NAME <u>not given</u>				14. MOTHER'S MAIDEN NAME <u>Patricia Ann Goforth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>mother</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>176X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 19____, to <u>6/24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6/24/60</u> , 19____, and that death occurred at _____ M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. H. Diamond</u>				ADDRESS (Street, city or town, state) <u>5248 Georgia Ave</u> DATE SIGNED <u>6/24/60</u>			
PHYSICIAN'S NAME (Type) <u>H. H. DIAMOND</u>				M.D. <u>7701 Silver Spring Rd</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>6-28-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wash. Sanitarium & Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Takoma Park Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert HARR, M.D., Wash. San. & Hosp. Takoma Park, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>Jul 6 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2-2-7520 2-461

7129

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
c. LENGTH OF STAY IN 1b <u>3 1/2</u>				d. STREET ADDRESS <u>10010 Frederick Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sumner Hall</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomasina Hardy Goodwin</u>				4. DATE OF DEATH Month Day Year <u>June 25, 1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/15/1905</u> yrs	
9. AGE (In years last birthday) <u>54</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>private</u>			
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>			
13. FATHER'S NAME <u>Charles Goodwin</u>				14. MOTHER'S MAIDEN NAME <u>Hardy (TALCOTT)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO <u>None</u>			
INFORMANT <u>Thomasina Hardy Goodwin, 10010 Frederick Ave.</u>				Address <u>Hyattsville, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>							
DUE TO <u>420.1</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Thrombosis</u>							
DUE TO (c) <u>Coronary atherosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Indefinite</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb. 2, 1957</u> , to <u>6/25</u> , 1960, that I last saw the deceased alive on <u>6/25, 1960</u> , and that death occurred at <u>6:30</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stephen W. Jones</u> M.D.				ADDRESS (Street, city or town, state) <u>Rockville, Md.</u>			
DATE SIGNED <u>6/26/60</u>							
PHYSICIAN'S NAME (Type) <u>Stephen W. Jones</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>6/29/60</u>		<u>LOCUST PARK</u>		<u>BALTIMORE, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u> ADDRESS <u>Wash. P. O. Box 1400 Chapin St. N.W.</u>				24a. REC'D BY REGISTRAR <u>DATE JUN 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07062

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN TB 1 1/2 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban			d. STREET ADDRESS 1619 61 st. Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Claymond Middle August Last Graham			4. DATE OF DEATH Month June Day 12 Year 19 60		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 20/1924		9. AGE (In years last birthday) 35 3/4 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Sanitary Commission		11. BIRTHPLACE (State or foreign country) Pa.	
13. FATHER'S NAME John Graham			14. MOTHER'S MAIDEN NAME Edna Thomas		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes.		16. SOCIAL SECURITY NO. 2018 11 66		17. INFORMANT Address wife (Clarence house) name	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Herniation of Brain Stem DUE TO Intracerebral Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Basal Skull Fracture DUE TO Basal Skull Fracture					INTERVAL BETWEEN ONSET AND DEATH Sudden 2 hours 2 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Was driven of auto which went out of control & upset					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 7:15 p.m. Month, Day, Year 6-12 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 213 R-270		20f. (City or town) (County) (State) Rockville monty md
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Frank J. Broschant		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6-13-60	
EXAMINER'S NAME (Type) FRANK J. Broschant		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-16-1960		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat	
22d. LOCATION (City, town, or county) (State) Wash D.C.		23. FUNERAL DIRECTOR'S SIGNATURE George A. Nelson		24a. REC'D BY REGISTRAR DATE JUN 15 '60	
24b. REGISTRAR'S SIGNATURE John S. ...					

TO DEPT. OF HEALTH: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **02063**

7131

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (If in hospital, give street address) <u>9301 Weaver Street</u>		d. STREET ADDRESS <u>1707 University Blvd. Md. 28.</u>	
3. NAME OF DECEASED (Type or print) <u>KATHRYN ENFIELD GRIGG</u>		4. DATE OF DEATH <u>June 28 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-10-69</u>
9. AGE (In years last birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>18</u> Hours <u></u> Min <u></u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lori Enfield</u>		14. MOTHER'S MAIDEN NAME <u>Louise Fredricks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Dr. Oliver Thompson</u>		Address <u>1707 University Blvd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>myocardial infarction</u> 420.0 DUE TO <u>Acute Pulmonary Cong.</u> Cohensions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Arteriosclerosis Heart D.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 da.</u> <u>wk.</u> <u>3 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 5 1958</u> to <u>June 26 1960</u> , that I last saw the deceased alive on <u>June 26 1960</u> , and that death occurred at <u>10:05</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Oliver E. Thompson</u> M.D.		ADDRESS (Street, city or town, state) <u>901 Pershing Dr. S.S. Md.</u>	
PHYSICIAN'S NAME (Type) <u>OLIVER E. THOMPSON</u>		DATE SIGNED <u></u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>June 30, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fair Lincoln Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> ADDRESS <u>254 Carroll St. N.W. D.C.</u>		24a. REC'D BY REGISTRAR <u>JUL 1 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7132 CERTIFICATE OF DEATH

07065

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Virginia STATE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria			
c. LENGTH OF STAY IN 1b 1 hr.				d. STREET ADDRESS 307 Wellington Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Gerald Middle Leslie Last HANN				4. DATE OF DEATH Month June Day 15 Year 19 60			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-21-60	9. AGE (In years last birthday) yrs 4	IF UNDER 1 YEAR Months 4 Days 25	IF UNDER 24 HRS Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Maryland		12. CIT. ZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edgar L. HANN				14. MOTHER'S MAIDEN NAME Pattie PACE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure and 154.5 DUE TO (b) apneic spell Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) cor biloumure						INTERVAL BETWEEN ONSET AND DEATH 10 min. 4 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mongolism						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from June 7 19 60 to June 15 19 60 that (2) (we) last saw the deceased alive on June 15 19 60 , and that death occurred at 3:12 PM , from the causes and on the date stated above.							
22a. SIGNATURE G. B. Avery, LT, MC, USN				22b. ADDRESS U. S. Naval Hospital, Bethesda, Md.		22c. DATE SIGNED 6-16-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/20/60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Wheatly Funeral Home, Alexandria, Va.				25a. REC'D BY REGISTRAR DATE JUN 17 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

2051421XV2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7029

07066

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>10 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8405 Piney Branch Rd</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8405 Piney Branch Rd</u>	
3. NAME OF DECEASED (Type or print) <u>John Bartholomew Hanson</u> 4. DATE OF DEATH <u>June 14 1960</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>May 5 1904</u> 9. AGE (In years) <u>55</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. (last birthday) Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dep. Com</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.C.</u> 11. BIRTHPLACE (State or foreign country) <u>Iowa</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>		13. FATHER'S NAME <u>Geo Hanson</u> 14. MOTHER'S MAIDEN NAME <u>Cora Reunick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>7-18-60</u> 17. INFORMANT <u>Lena Hanson (wife)</u> Address <u>Stun 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Throat hemorrhage</u> DUE TO (b) <u>Shot gun wound in left chest (heart)</u> DUE TO (c) <u>suicide</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Year <u>3:30 p.m. 6-14 1960</u> 20d. INJURY OCCURRED <u>Self-inflicted shot gun wound</u> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Silver Spring</u> (County) <u>Montg</u> (State) <u>md</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Frank J. Broschaw</u> NAME (Type) <u>FRANK J. BROSCAW</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>6-18-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>June 20, 1960</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Hillview Cemetery</u> 22d. LOCATION (City, town, or country) (State) <u>Hinsdale, Montana</u>		23. FUNERAL DIRECTOR <u>J. Arthur Walters, 254 Carroll St NW DC</u> 24a. REC'D BY REGISTRAR <u>JUN 17 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Charles S. Kneass</u>	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7133 **CERTIFICATE OF DEATH**

07067

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>97 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				2. USUAL RESIDENCE (Where deceased lived. If institut on: Res dence before admiss on) a. STATE <u>Pennsylvania</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Emmas</u> d. STREET ADDRESS <u>349 Spruce Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Foster</u> Last <u>Harries</u>				4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1960</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 31, 1920</u>		9. AGE (In years lost birthday) <u>39</u> yrs IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> IF UNDER 24 HRS: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Textile Manufacturer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Textile</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Herbert D. Harries</u>				14. MOTHER'S MAIDEN NAME <u>Mamie Muhs</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO <u>151-14-7655</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u> DUE TO (b) <u>Acute myelocytic leukemia</u> DUE TO (c) <u> </u> (Condit ans, if any, which gave rise to immediate cause (a), stating the underlying cause last.)								INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>10 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Leukemic infiltration of liver, kidneys, spleen, lymph nodes, and bone marrow</u>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 12</u> <u>1960</u> to <u>June 17</u> <u>1960</u> that (I) (we) last saw the deceased alive on <u>June 17</u> <u>1960</u> and that death occurred at <u>4:25 PM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Paul J. Schwab</u>				22b. DATE SIGNED <u>6/19/60</u>		22c. PHYSICIAN'S NAME (Type) <u>PAUL J. SCHWAB, M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>			
23a. BURIAL, CREMATION, OR REMOVAL (Specify)		23b. DATE THEREOF <u>6-21-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grandview Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Allentown, Penna</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>				ADDRESS <u>Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE JUN 21 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
M
051
1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7134
CERTIFICATE OF DEATH

07068

1 PLACE OF DEATH COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) STATE Maryland b. COUNTY Cecil	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 4 days	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS 258 Laffey Circle, Manor Hgts.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Michael Middle Arthur Last HARTLE		4 DATE OF DEATH Month June Day 13 Year 1960	
5 SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 7-3-55
9 AGE (In years last birthday) 4 yrs		IF UNDER 1 YEAR Months 4 Days 13 Hours 13 Min 00	IF UNDER 24 HRS. Hours 13 Min 00
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Arthur W. HARTLE		14. MOTHER'S MAIDEN NAME Julia Rose GOBEO	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (F) Arthur W. Hartle, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) B. hemorrhaging and right heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) fibrotic disease of pancreas (c) chronic malnutrition due to ulcers		INTERVAL BETWEEN ONSET AND DEATH 5 days 5 days 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) chronic malnutrition due to ulcers		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) physician attended the deceased from June 9 19 60 to June 13 19 60 , that (I) yes saw the deceased alive on June 13 19 60 , and that death occurred at 11:50 am from the causes and on the date stated above.			
22a SIGNATURE G. B. Avery, Lt, MC, USN		22b. DATE SIGNED 6-13-60	
22c PHYSICIAN'S NAME (Type) G. B. Avery, Lt, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery	
23c. DATE THEREOF 6-14-60		23d. LOCATION (City, town, or county) (State) Middletown New York	
24. FUNERAL DIRECTOR'S SIGNATURE Walsh Funeral Home, 741 11th St., SE, WashDC		25a. REC'D BY REGISTRAR JUN 16 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Haines			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A11ME
5M 7/59

MD. STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7053

Item 14, Film G-272 10/3/60 cac.

07069

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH. SANITARIUM</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>214 Silver Spring</u> d. STREET ADDRESS <u>132 Eastbrook Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Blythe</u> Last <u>Hayden</u> 4. DATE OF DEATH Month <u>6</u> Day <u>2</u> Year <u>1960</u>		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Month <u>5</u> Day <u>13</u> Year <u>1960</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>WASH. D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter J. Hayden</u>		14. MOTHER'S MAIDEN NAME <u>Grace K. Lucas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give word and date of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Mr Woodrow Lucas</u>	
17. INFORMANT <u>Some 95ABW</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>475X</u> DUE TO (b) <u>upper Respiratory Infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brosch</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-4-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Marys Cem</u>		22d. LOCATION (City, town, or country) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR <u>Deal Funeral Home</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
ADDRESS <u>4812 Ga An hwy</u>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

VS. A11ME
5M 7/59

VS. A11ME
5M 7/59

VS. A11ME
5M 7/59

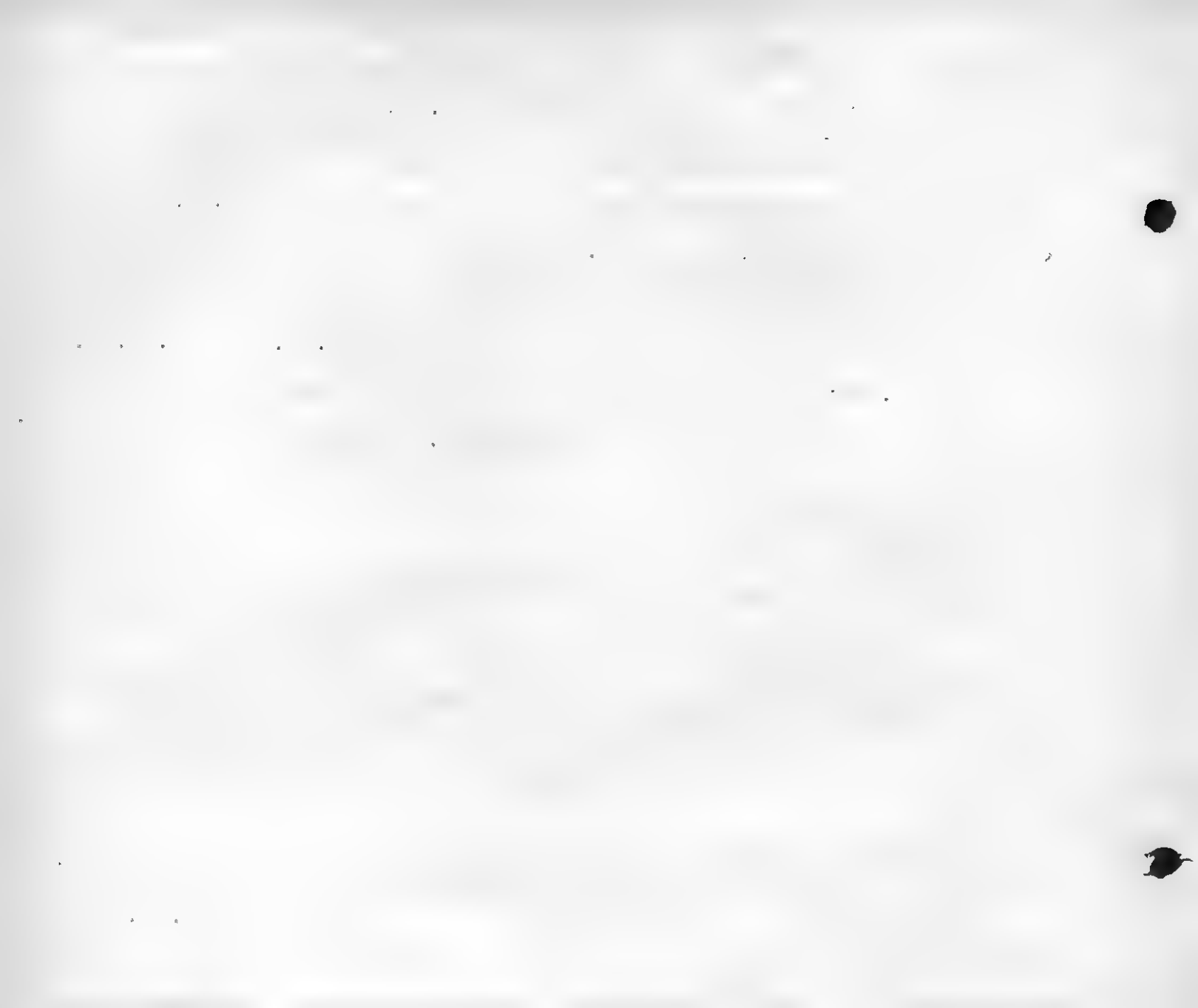
7080

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07070

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b unknown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. STREET ADDRESS 1954 Columbia Road N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lilian Middle D. Last Heath		4. DATE OF DEATH Month June Day 11 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/20/1884
9. AGE (In years last birthday) 76 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Felix M. Draney		14. MOTHER'S MAIDEN NAME Salome Harrison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT William D. Heath-1111 Army Navy Dr.		Address Arlington, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia 20.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure DUE TO (c) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 10 days 1 month 5 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 28 1949 to June 11 1960 that (I) (we) last saw the deceased alive on June 10 1960 and that death occurred at 11 PM , from the causes and on the date stated above.			
22a. SIGNATURE Horace H. Custis Jr. M.D.		22b. DATE SIGNED June 11/1960	
22c. PHYSICIAN'S NAME (Type) HORACE H. CUSTIS JR		22d. ADDRESS 1852 Columbia Rd NW	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/14/60	
23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Wash D. C.		25a. REC'D BY REGISTRAR JUN 14 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Hines			



MEDICAL CERTIFICATION	1. PLACE OF DEATH a. COUNTY Montgomery	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	b. COUNTY Montgomery
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b 5 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Chevy Chase	
	d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Congressional Manor	d. STREET ADDRESS 3912 Leland Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
	3. NAME OF DECEASED (Type or print) Lucy Knight Heyl	First Middle Last	4. DATE OF DEATH Month Day Year June 24 1960	
	5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/23/1869
	9. AGE (In years lost birthday) 91 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 2 1	IF UNDER 24 HRS Hours Min. 1	
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) Pennsylvania	12. CITIZEN OF WHAT COUNTRY? USA
	13. FATHER'S NAME Nathan Delaney Daugherty	14. MOTHER'S MAIDEN NAME Mary Elizabeth Antis		
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Paul R. Heyl-Husband-same 2d	Address
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 600.0 DUE TO Mitral Insufficiency with cardiac hypertrophy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pyelonephritis DUE TO (c) Cerebro-vascular accidents	INTERVAL BETWEEN ONSET AND DEATH over 50 yrs. 2 yrs. 4 yrs.		
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
	20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
	21. I certify that (I) (this hospital) attended the deceased from Nov. 18, 1956 to June 24, 1960 that (I) (we) last saw the deceased alive on June 24, 1960 and that death occurred at 6:40 A.M. from the causes and on the date stated above.			
	22a. SIGNATURE Katharine A. Chapman M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. ADDRESS Kensington Bethesda, Maryland	22c. DATE SIGNED June 24, 1960
	23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 6/24/60	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION (City, town or county) (State) Suitland, Maryland
	24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland	ADDRESS	25a. REC'D BY REGISTRAR DATE JUN 27 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Hines

54

07072

7054

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hosp</u>		d. STREET ADDRESS <u>5609 29th Street Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>HERMAN</u> Middle <u>Elroy</u> Last <u>NIATH</u>		4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-13-16</u>
9. AGE (In years last birthday) <u>44</u> yrs		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DELIVER. SCOUT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Army Map Service</u>	
11. BIRTHPLACE (State or foreign country) <u>Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>William Henry Niath</u>		14. MOTHER'S MAIDEN NAME <u>Cynthia Presnole</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>Apac-Ameres</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY INSUFFICIENCY</u> DUE TO <u>451-1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BRONCHOPNEUMONIA, EARLY, BILATERAL.</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-6</u> 19 <u>60</u> , to <u>June 8</u> 19 <u>60</u> that I last saw the deceased alive on <u>April 6</u> 19 <u>60</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Leon L. Gallin M.D.</u>		DATE SIGNED <u>9/8/60</u>	
PHYSICIAN'S NAME (Type) <u>LEON L. GALLIN M.D.</u>		<u>7206 Colesville Rd., W. Hyattsville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>June 13, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u>		24a. REC'D BY REGISTRAR <u>5801-Cleveland</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kines</u>		DATE <u>JUN 13 '60</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

07073

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>RETTA</u> First <u>C</u> Middle <u>Hickey</u> Last				4. DATE OF DEATH <u>JUNE 2</u> 1960 Month <u>June</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1918</u> 19 <u>18</u> 1874 <u>85</u> yrs.	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Robert S HICKP</u>			
14. MOTHER'S MAIDEN NAME <u>Lillian Hickey</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>101-10-1010</u>				17. INFORMANT <u>Genevieve Wallace</u> Address <u>(DATA)</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO <u>332X</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last (b) <u>Cerebral arteriosclerosis</u> DUE TO <u>several years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Diabetes</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb</u> 1960, to <u>6/2/1960</u> , that I last saw the deceased alive on <u>5/20/1960</u> , and that death occurred at <u>5:00</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald Nelson</u>				ADDRESS (Street, city or town, state) <u>10620 Georgia Ave, Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Donald Nelson</u>				DATE SIGNED <u>June 6 '60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6-6-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lynnhurst</u>		22d. LOCATION (City, town, or county) (State) <u>Shopsville Tenn</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. M. Lee</u> ADDRESS <u>300 4th St. N.E. Wash DC</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon to page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

X



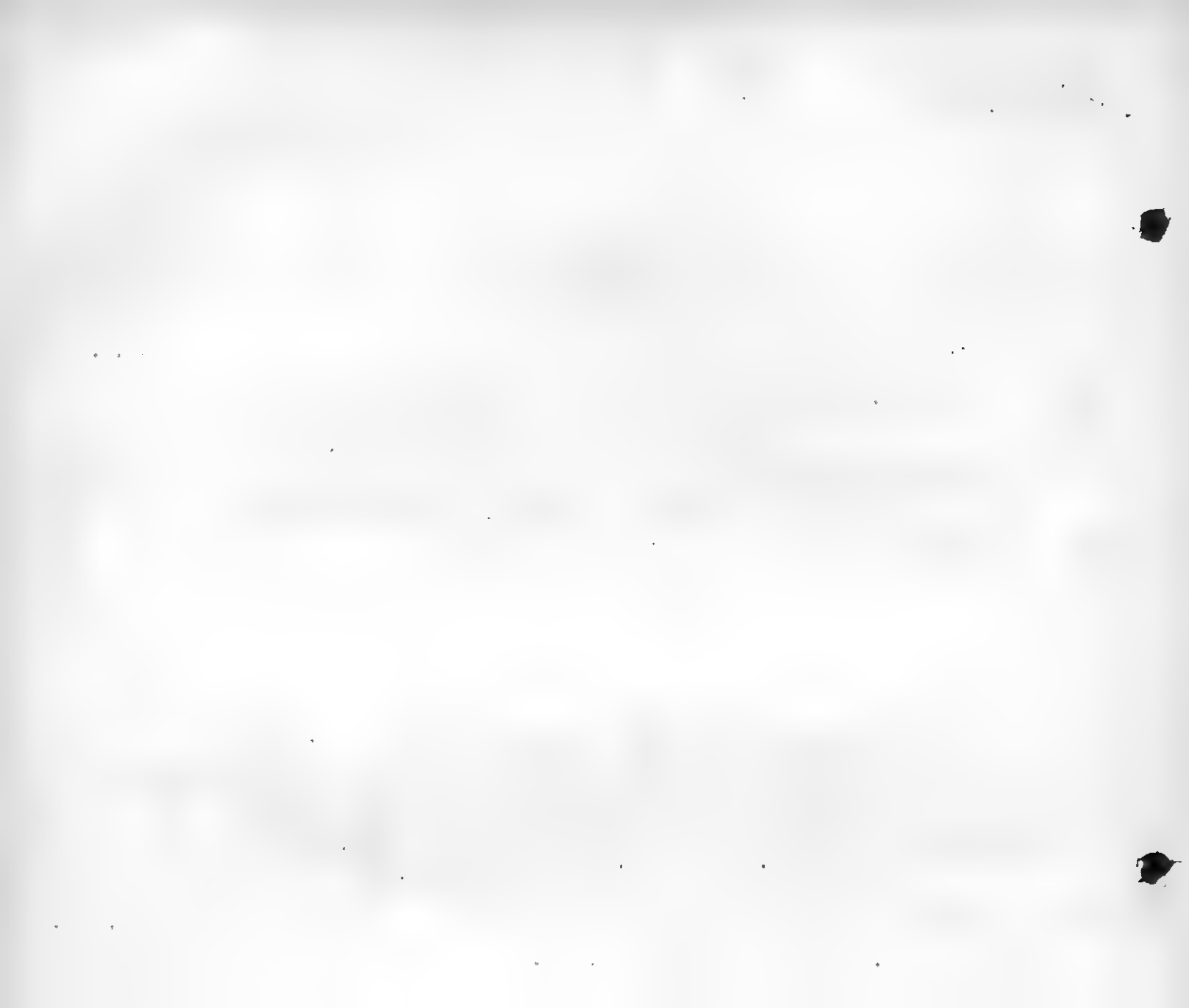
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07074

7135

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Texas</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>117 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dallas</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>6023 Lupton Drive</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Marjorie</u> Middle <u>Louise</u> Last <u>Hill</u>				4. DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>19 60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 4, 1923</u>		9. AGE (In years last birthday) <u>36</u> yrs	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min _____	IF UNDER 24 HRS Hours _____ Min _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hubbard T. Bowyer</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Wills</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gram negative rod septicemia</u> DUE TO (b) <u>Carcinoma of the adrenal cortex with metastasis to liver and abdominal cavity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> 1 <u>1</u> years							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>February 25, 1960</u> to <u>June 21, 1960</u> , that (I) (we) lost saw the deceased alive on <u>June 21, 1960</u> , and that death occurred on <u>June 21, 1960</u> from the causes and on the date stated above							
22a. SIGNATURE <u>Gordon C. Sharp</u> M.D.				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> <u>6/21/60</u> 22b. ADDRESS <u>The Clinical Center, NIH Bethesda 14, Maryland</u>			
22c. PHYSICIAN'S NAME (Type) <u>Gordon C. Sharp, M.D.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>6-22-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>				ADDRESS <u>Bethesda, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 22 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7137 **CERTIFICATE OF DEATH**

07075

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY			c. LENGTH OF STAY IN 1b 14 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SANDY SPRING		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY CO. GENERAL HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last SAMUEL BERNARD HILL				4. DATE OF DEATH Month Day Year JUNE 14, 1960			
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 4-11-1898		9. AGE (In years last birthday) yrs. 62	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL T. HILL				14. MOTHER'S MAIDEN NAME MARY ELLEN KING			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give year or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORDS		Address OLNEY, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div> <p>PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ③ Pulmonary emboli</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. ② Pulmonary vein Thrombosis</p> <p>① Diabetes Mellitus</p> <p>④ Pulmonary infarctions</p> </div> <div> <p>INTERVAL BETWEEN ONSET AND DEATH 10 days</p> </div> </div>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3 June 1960 to 14 June 1960 that (I) (we) last saw the deceased alive on 14 June 1960 and that death occurred at 2 PM , from the causes and on the date stated above.							
22a. SIGNATURE John B. Ziegler M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 14 June 1960	
22c. PHYSICIAN'S NAME (Type) J. B. ZIEGLER, M.D.				22d. ADDRESS OLNEY, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/17/60		23c. NAME OF CEMETERY OR CREMATORY Sandy Spring		23d. LOCATION (City, town, or county) (State) Sandy Spring, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Howard				ADDRESS Rockville, Md.		25a. REC'D BY REGISTRAR JUN 16 '60	
				25b. REG. STRAR'S SIGNATURE Arthur S. Howard			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

7138

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07076

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>18 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8812 Ridge Rd</i>		d. STREET ADDRESS <i>8812 Ridge Road</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Ethel</i> Middle <i>Bessie</i> Last <i>HODGES</i>		4. DATE OF DEATH Month <i>June</i> Day <i>30</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>24 Nov. 1865</i>
9. AGE (In years lost b. m. day) <i>94</i> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>London, England</i>		12. CITIZENSHIP OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Kirkus</i>		14. MOTHER'S MAIDEN NAME <i>Harriett Lane</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT Address <i>Mrs. Adolph Schow, 8812 Ridge Road.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332X Congestive heart failure</i> DUE TO (b) <i>Generalized arteriosclerosis</i> Conditions; if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i>6 years</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Progressive cerebral thrombosis</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>June 1957</i> to <i>30 June 1960</i> , that (I) last saw the deceased alive on <i>27 June 1960</i> , and that death occurred at <i>12:30 PM</i> , from the causes and on the date stated above			
22a. SIGNATURE <i>Robert R. Belton</i>		22b. DATE SIGNED <i>6/30/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>Robert R. Belton</i>		22d. ADDRESS <i>919 - 18th St. N.W., Washington, D.C.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7/2/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Glenwood Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Washington, D. C.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		25a. REC'D BY REGISTRAR <i>JUL 5 '60</i>	
ADDRESS <i>Bethesda, Maryland</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneass</i>	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and to any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7074

07077

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mntg</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg (rural)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Emory Grove</u>		d. STREET ADDRESS <u>1 Emory Grove</u>	
3. NAME OF DECEASED (Type or print) <u>Carroll Wm Howard</u>	4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>1960</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-6-1950</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>school</u>	9b. KIND OF BUSINESS OR INDUSTRY	9c. BIRTHPLACE (State or foreign country) <u>md</u>	9d. AGE in years (last birthday) <u>10</u> yrs. IF UNDER 1 YEAR: Months <u>18</u> Days <u>18</u> Hours <u>18</u> Min. IF UNDER 24 HRS: Months <u>18</u> Days <u>18</u> Hours <u>18</u> Min.
10a. FATHER'S NAME <u>Lawrence Howard</u>	10b. MOTHER'S MAIDEN NAME <u>Lourena E. Chambers</u>	11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	12. SOCIAL SECURITY NO.	13. INFORMANT <u>Lawrence Howard - Steve</u> Address <u>2</u>	
14. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 929.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>choking</u> (a), stating the underlying cause last. DUE TO (c)		15. INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
16. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		17. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Was swimming in pond & drowned</u>	
18. TIME OF INJURY Hour <u>2:30</u> p.m. Month, Day, Year <u>6-30-1960</u>	19. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Pond</u>	21. (City or town) <u>Gaithersburg</u> (County) <u>mntg</u> (State) <u>md</u>
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquest <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23. BURNAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24. DATE THEREOF <u>7/3/60</u>	
25. NAME OF CEMETERY OR CREMATORY <u>Brooke Greve.,</u>		26. LOCATION (City, town, or country) <u>Laytonsville, Md.</u> (State) <u>md</u>	
27. FUNERAL DIRECTOR <u>Robert L. Samuels</u>		28. ADDRESS <u>Rockville, Md.</u>	
29. REC'D BY REGISTRAR <u>JUL 5 '60</u>		30. REGISTRAR'S SIGNATURE <u>Carlton L. Knecht</u>	



may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be returned with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4
M
X
1

4.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7030 CERTIFICATE OF DEATH 07078

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4424 Mahan Road		d. STREET ADDRESS 4424 Mahan Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ETHEL IRENE HUDSON		4. DATE OF DEATH Month Day Year June 2 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6/22/09
9. AGE (In years last birthday) 50 yrs		IF UNDER 1 YEAR Months Days Hours Min. 50	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESLADY		10b. KIND OF BUSINESS OR INDUSTRY H. L. GREFNE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES SIMMONS		14. MOTHER'S MAIDEN NAME FLORENCE ELIZABETH unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO 217-30-6655	
17. INFORMANT Address Mr. John W. Hudson, Jr., 4424 Mahan Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Stomach DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Silver Spring, Md. DUE TO (c) Interval between onset and death 6 weeks			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 10/29/1956 to 6/2/1960 that (I) (we) last saw the deceased alive on 5/24/1960 and that death occurred at 12:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Russell B. Arnold M.D.		22b. DATE SIGNED 6/2/60	
22c. PHYSICIAN'S NAME (Type) Russell B. Arnold M.D.		22d. ADDRESS 4424 Mahan Rd.	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/5/60	
23c. NAME OF CEMETERY OR CREMATORY MURRANDY CEMETERY		23d. LOCATION (City, town, or county) (State) HUNTINGTOWN, CALVERT COUNTY, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Edmond A. Ziska		25a. REC'D BY REGISTRAR JUN 9 '60	
ADDRESS SILVER SPRING, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Kimes	



7055

CERTIFICATE OF DEATH

Reg. Dis. No. 07079

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>10 days</u>		d. STREET ADDRESS <u>16509 Rodney Rd - Hillendale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>ROBERT</u> Last <u>HUSSONG</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>5</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 21-1946</u>
9. AGE (In years last birthday) <u>14</u> yrs		IF UNDER 1 YEAR Months <u>14</u> Days <u>5</u> Hours <u>19</u> Min <u>60</u>	IF UNDER 24 HRS. Months <u>14</u> Days <u>5</u> Hours <u>19</u> Min <u>60</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ohio</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>DR FRANK ROBERT HUSSONG</u>		14. MOTHER'S MAIDEN NAME <u>HAZEL WILLIAMS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hospital Records</u>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>Glioblastoma, left cerebral hemisphere</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>9 mos</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>several hours</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>January</u> , 1960, to <u>JUNE 5</u> , 1960, that I last saw the deceased alive on <u>JUNE 4</u> , 1960, and that death occurred at <u>6:29 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bennet A. Porter, Jr., M.D.</u>		ADDRESS (Street, city or town, state) <u>9301 Colesville Rd., Silver Spring, Md.</u>	
DATE SIGNED <u>JUNE 5, 1960</u>			
PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr., M.D.</u>		<u>9301 Colesville Rd., Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>	22b. DATE THEREOF <u>June 7, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Walter</u>		24a. REC'D BY REGISTRAR <u>Arthur S. House</u>	
ADDRESS <u>264 Carroll St NW</u>		DATE <u>JUN 7 '60</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

150

7

7139

CERTIFICATE OF DEATH

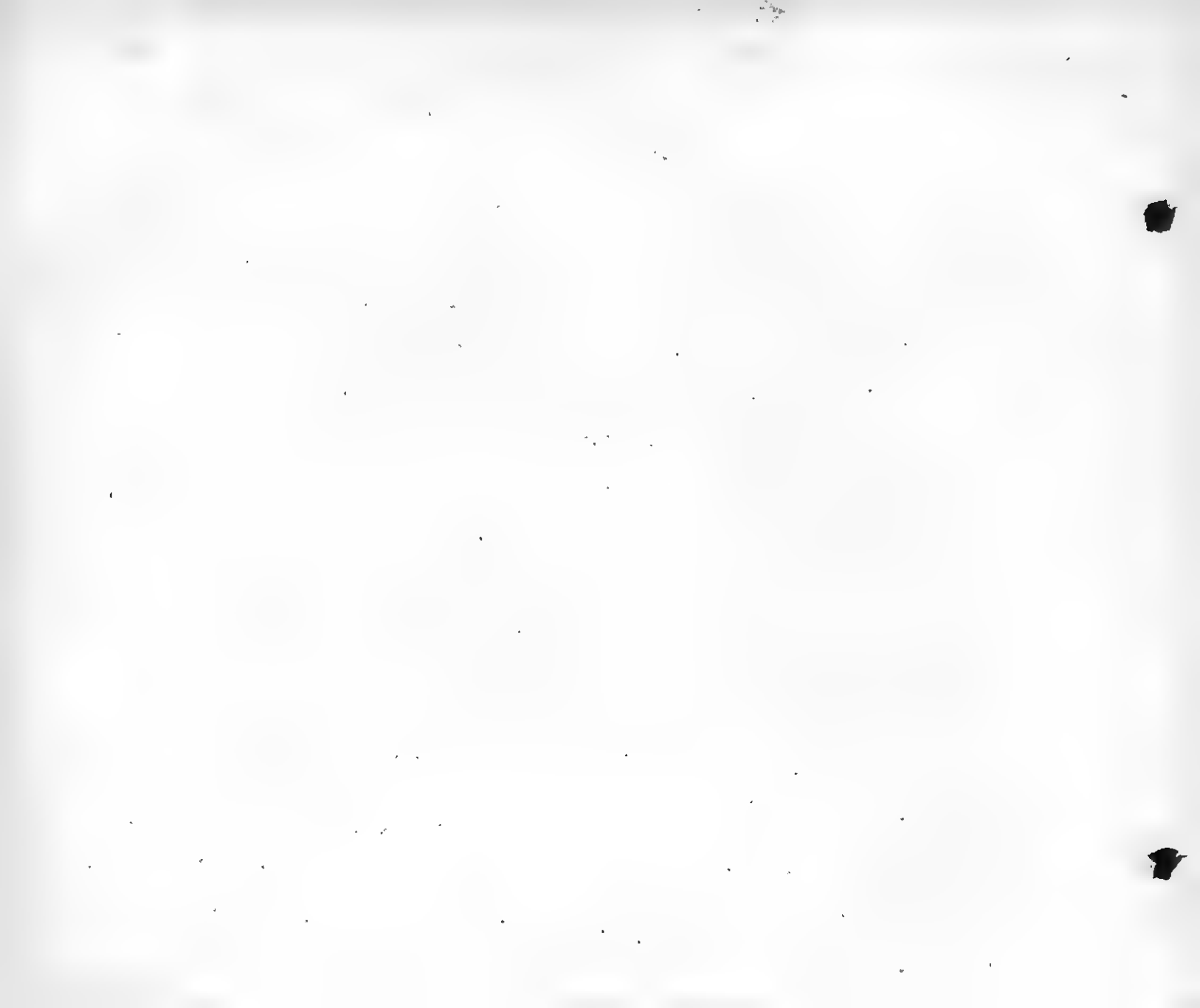
Reg. Dist. No.

07080

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 36 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 44			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS 4833 Broadbrook Drive			
3. NAME OF DECEASED (Type or print) First Louis Middle J Last Illis				4. DATE OF DEATH Month June Day 28 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 26, 1888	
9. AGE (In years lost birthday) 71 yrs.		IF UNDER 1 YEAR Months 7 Days 1 Hours 1 Min.		IF UNDER 24 HRS Months 7 Days 1 Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) Hungary	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Stephen Illis				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) W. War T				16. SOCIAL SECURITY NO. 137-05-4738A			
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO SIX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) MALIGNANT CACHEXIA DUE TO CARCINOMA OF STOMACH (c) PULMONARY EMPHYSEMA				INTERVAL BETWEEN ONSET AND DEATH 48 hours 4 MONTHS 1 YEAR			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY EMPHYSEMA				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from AUG 17 , 19 59 , to JUNE 28 , 19 60 that I last saw the deceased alive on JUNE 27 , 19 60 , and that death occurred at 3:35 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert G. Angle				ADDRESS (Street, city or town, state) 5009 Del Ray Ave Bethesda, Md			
DATE SIGNED 4/29/60							
PHYSICIAN'S NAME (Type) Robert G. Angle				5009 DelRay Ave. Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/30/60		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey				24a. REC'D BY REGISTRAR JUN 30 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7140

CERTIFICATE OF DEATH

07081

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institut on: Residence before admission) a. STATE District of Columbia COUNTY ✓			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 80 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 15			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 5408 30th Place, NW		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Ernest Middle Lee Last Jackson				4. DATE OF DEATH Month June Day 14 Year 1960			
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 27, 1891		9. AGE (In years last birthday) yrs 68	IF UNDER 1 YEAR Months 6 Days 14 Hours 14 Min 14	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Research Chemist		10b. KIND OF BUSINESS OR INDUSTRY Government (Retired)		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Benjamin F. H. Jackson				14. MOTHER'S MAIDEN NAME Martha Capps			
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16 SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Multiple Myeloma DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 48 hours 3 Years
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from March 26 19 60 to June 14 19 60 , that (I) (we) last saw the deceased alive on June 14 19 60 , and that death occurred at 8:45 PM , from the causes and on the date stated above.							
22a SIGNATURE Charles E. Mengel M.D.				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b DATE SIGNED 6-14-60	
22c PHYSICIAN'S NAME (Type) CHARLES E. MENGEL, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a BURIAL CREMATION, REMOVAL (Specify) burial		23b DATE THEREOF 6/17/60		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d LOCATION (City, town, or county) (State) Washington, D.C.	
24 FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				25a REC'D BY REGISTRAR DATE JUN 16 '60		25b REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, and completely filled in by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



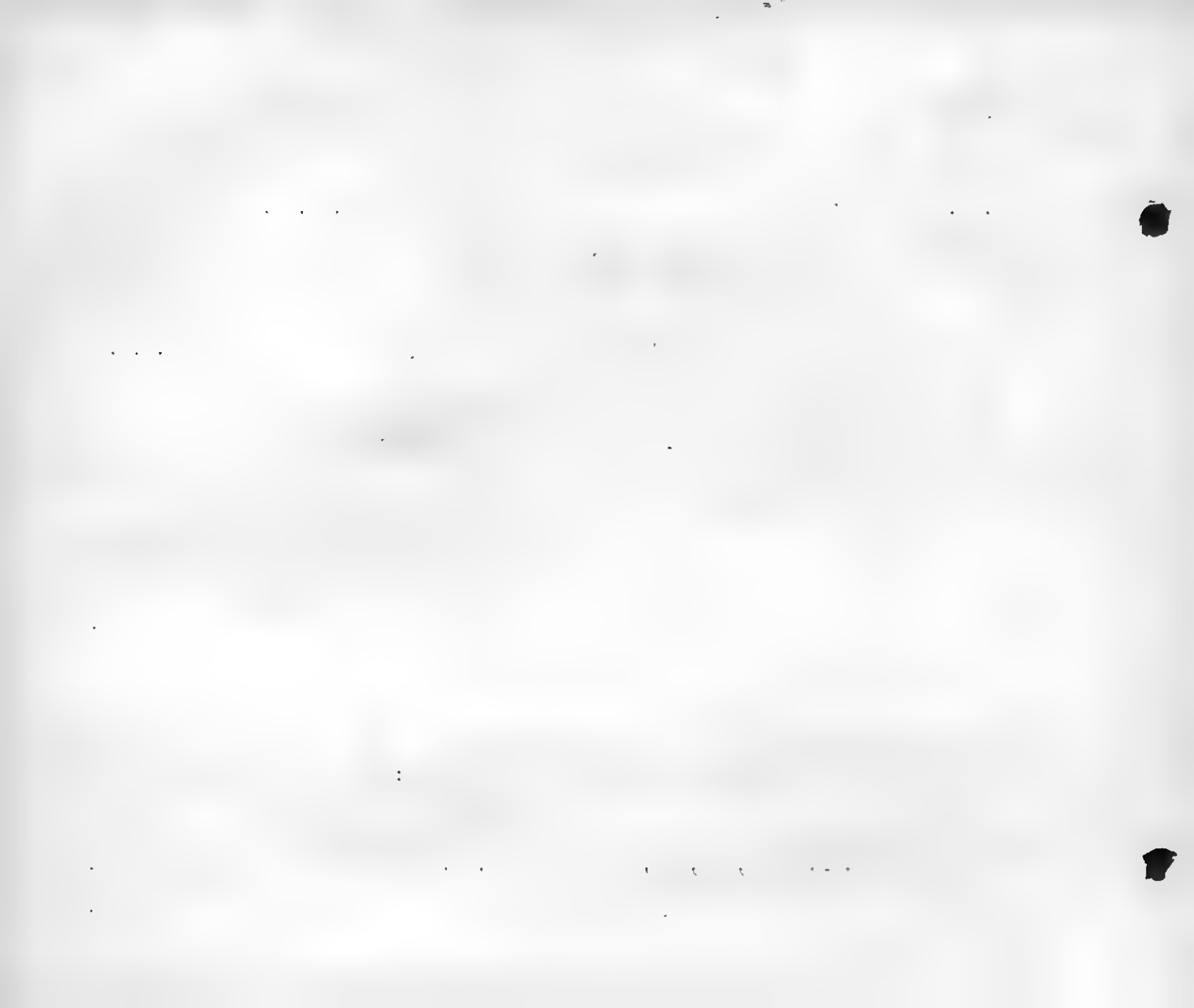
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7141
CERTIFICATE OF DEATH

07082

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY <input checked="" type="checkbox"/>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 23 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 315 12th Street, N. E.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last George Henry JACKSON				4. DATE OF DEATH Month Day Year June 15 1960							
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-29-08		9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Issac JACKSON				14. MOTHER'S MAIDEN NAME Bessie BIRD							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes 1943-1947				16. SOCIAL SECURITY NO 577-07-9820		17. INFORMANT Hospital Records				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Mediastatic carcinoma DUE TO (b) Carcinoma stomach DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 month 1 month											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) you you attended the deceased from May 23 1960 to June 15 1960 , that (1) you you saw the deceased alive on June 15 1960 , and that death occurred at 11:50 am , from the causes and on the date stated above.											
22a. SIGNATURE V. N. HOOK, LT, MC, USN						22b. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6-24-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Barnes & Matthews, 3619 14th St., NW, WashDC						25a. REC'D BY REGISTRAR JUN 17 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kline			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

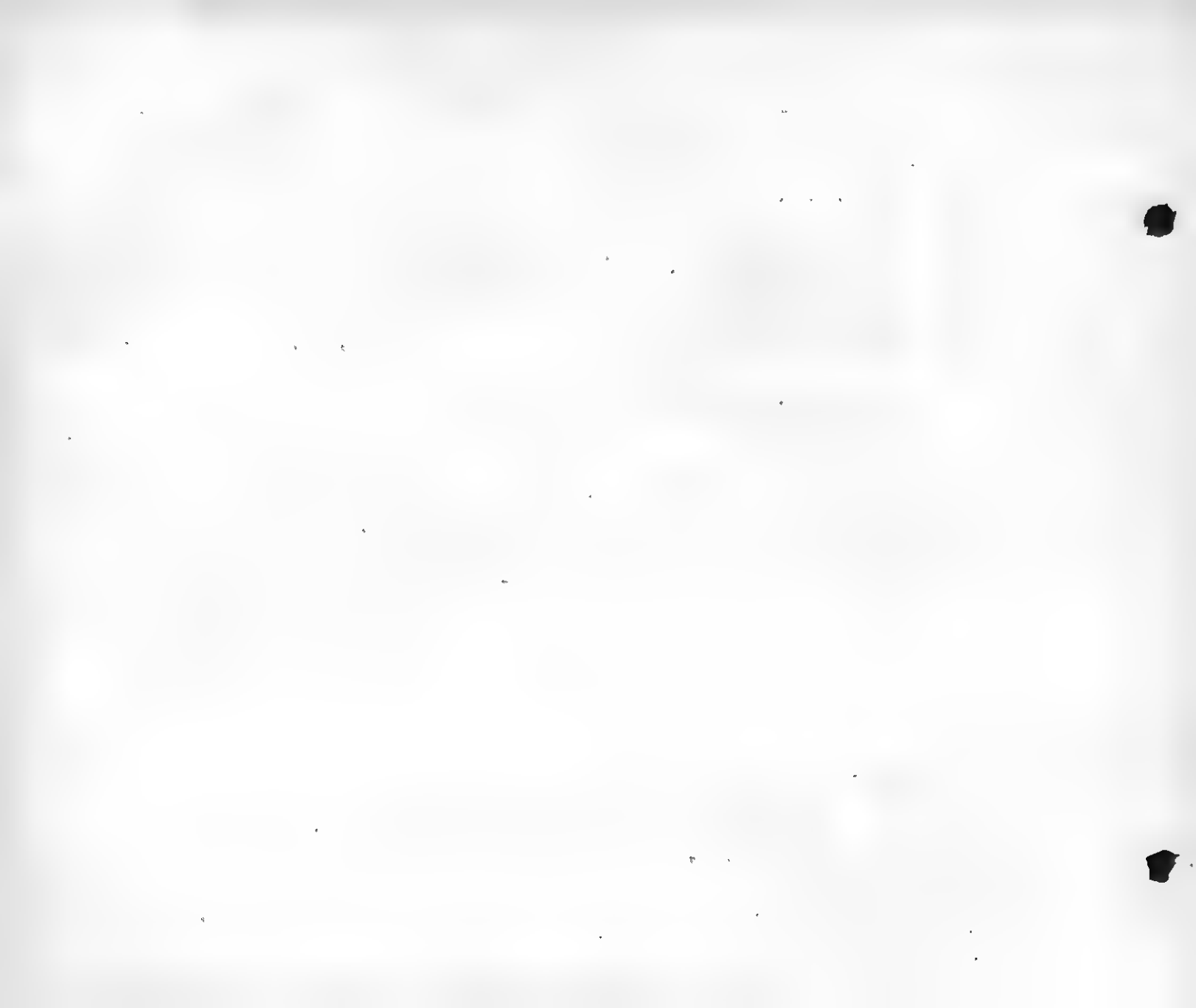
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7142

CERTIFICATE OF DEATH

Reg. Dist. No. 17083

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairland	
c. LENGTH OF STAY IN 1b life		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last George T. Jackson		4. DATE OF DEATH Month Day Year June 25 1960	
5 SEX male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1891
9. AGE (In years last birthday) 69 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life or retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY general	
11. BIRTHPLACE (State or foreign country) Fairland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George S. Jackson		14. MOTHER'S MAIDEN NAME Martha Lee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO INFORMANT Emory Lee Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4112X DUE TO Uremic Comma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Arteriosclerosis Cerebral (c) Arteriosclerosis Renal no hypertension		INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED Wrote <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 16, 1960 , to June 25, 1960 , that I last saw the deceased alive on June 24, 1960 , and that death occurred at 10:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Norbeck Rt. 1 Silver Spring DATE SIGNED 6/27/60			
ACTUAL SIGNATURE Webster Sewell M.D.		PHYSICIAN'S NAME (Type) Webster Sewell	
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 6/28/60	
22c. NAME OF CEMETERY OR CREMATORY Round Oak Cemetery		22d. LOCATION (City, town, or county) (State) Spencerville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	
ADDRESS Rockville Md		24a. REC'D BY REGISTRAR DATE JUN 30 '60	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

(M)

(I)

MEDICAL CERTIFICATION

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07084

7143

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarkstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarkstown</u>			
c. LENGTH OF STAY IN <u>16 yrs</u>				d. STREET ADDRESS <u>Clarkstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospite, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Martha L. Jackson</u>				4. DATE OF DEATH <u>June 12 1968</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-18-1879</u>	
9. AGE (In years, F UNDER 1 YEAR IF UNDER 24 HRS. as birthday) <u>88</u> yrs. Months Days Hours Min				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>			
10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>md</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>David Snowden</u>			
14. MOTHER'S MAIDEN NAME <u>Rebecca Bowie</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Lorraine Foreman (daughter) Steen</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>70X</u> (b) <u>Chronic cardiac renal disease</u> DUE TO (c) <u>C. A. Rt. breast</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>2 mo</u> <u>1 1/2 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>6/15/60</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Purdum</u>				22d. LOCATION (City, town, or country) (State) <u>Purdum, Mi.</u>			
23. FUNERAL DIRECTOR <u>Robert L. Snowden</u>				24a. REC'D BY REGISTRAR <u>JUN 16 '60</u>			
ADDRESS <u>Rookville, Mi.</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7144

CERTIFICATE OF DEATH

07085

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>DC.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brookside Home For the Aged</u>				d. STREET ADDRESS <u>7361 First Foot Rd. S.E.</u>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Johnson</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>June</u> Day <u>10</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6, 1873</u>		9. AGE (In years last birthday) <u>87</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mississippi</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>New York'shire, England</u>		12. CITIZEN OF WHAT COUNTRY? <u>England</u> ✓	
13. FATHER'S NAME <u>Henry Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Rosalie Johnson</u> Address <u>7361 First Foot Rd. S.E. Wash. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Broncho Pneumonia</u> DUE TO <u>491X</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u>							
(c) <u> </u> DUE TO <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>				20g. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that I attended the deceased from <u>9-1</u> , 19 <u>59</u> to <u>6-10</u> , 19 <u>60</u> that I last saw the deceased alive on <u>6-10</u> , 19 <u>60</u> , and that death occurred at <u>1:08</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Roy B. Parsons</u> M.D.				ADDRESS (Street, city or town, state) <u>15410 Columbia Rd</u>			
PHYSICIAN'S NAME (Type) <u>Roy B Parsons Jr</u>				DATE SIGNED <u>Bartonsville Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-13-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u> ADDRESS <u>517-11th St. S.E.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07086

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1513 East Falkland Lane</u>		d. STREET ADDRESS <u>1513 East Falkland Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Joseph</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>19 60</u>	
5. SEX <u>male</u>	6. COLOR OF RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 8, 1883</u>
9. AGE (In years last birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Chemist (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>National Dairies</u>	
11. BIRTHPLACE (State or foreign country) <u>Wales</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas Hilton Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Seddon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>212-01-6626</u>	
17. INFORMANT <u>Mrs. Louise R. Johnson, 1513 E. Falkland Lane, SS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive pulmonary hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Carcinoma of the lungs</u> (c) <u> </u> [e], stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		DATE SIGNED <u>June 23, 1960</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/27/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Pumphrey, INC.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 29 '60</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

7032

CERTIFICATE OF DEATH

Reg. Dist. No. 07087

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>5</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jolles Joseph Isaac Jolles</u>		4. DATE OF DEATH <u>June 22 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 16 '89</u>
9. AGE (In years lost birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTH PLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jolles</u>		14. MOTHER'S MAIDEN NAME <u>Fay Bronneman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure - Pneumonia</u> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Artery, thrombosis, cerebral & venous</u> DUE TO (c) <u>Cardiovascular Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiovascular Heart Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/16</u> , 19 <u>59</u> , to <u>6/22</u> , 19 <u>60</u> that I last saw the deceased alive on <u>6/22</u> , 19 <u>60</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Benjamin Isaacson</u> M.D. <u>7735 Alaska Ave. N.W. Washington 12-D.C.</u>		DATE SIGNED <u>6/27/60</u>	
PHYSICIAN'S NAME (Type) <u>Benjamin Isaacson, M.D.</u>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6-23-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BNAI ISRAEL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>OXON HILL MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzansky</u> ADDRESS <u>3501 14th St NW Wash DC</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 24 '60</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

X



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

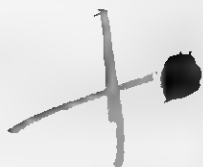
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7033

CERTIFICATE OF DEATH

07088

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Res dence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 6 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12,310 Brookhaven Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Walker Jones		4. DATE OF DEATH June 11, 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 19, 1869
9. AGE (In years last birthday) 90 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (retired) Cranesman		10b. KIND OF BUSINESS OR INDUSTRY B. & O. Railroad	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Findlay Jones		14. MOTHER'S MAIDEN NAME Sadie Connors	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 705-03-1683	
17. INFORMANT William J. Jones, son, 12,310 Brookhaven Drive,		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Chronic arteriosclerotic heart disease DUE TO (c) Generalized marked arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 4 days undetermined undetermined	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JAN 1957 to 11 JUN 1960 , that (I) (we) last saw the deceased alive on 9 JUN 1960 , and that death occurred at 7:00 PM , from the causes and on the date stated above.			
22a. SIGNATURE L. Marshall Cuvillier, Jr.		22b. DATE SIGNED 6/12/60	
22c. PHYSICIAN'S NAME (Type) L. Marshall Cuvillier, Jr.		22d. ADDRESS 1407 Woodside Parkway, Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 16, 1960	
23c. NAME OF CEMETERY OR CREMATORY Spring Hill		23d. LOCATION (City, town, or county) (State) Shippensburg, Cumberland, Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE WABNER E. PUMPHREY, INC.		25a. REC'D BY REGISTRAR DATE JUN 17 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



7087

CERTIFICATE OF DEATH

07089

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5704 Randolph Road				d. STREET ADDRESS 5704 Randolph Road	
3. NAME OF DECEASED (Type or print) JOHN		First Middle Last PARK KEISER		4. DATE OF DEATH Month Day Year June 30, 1960 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 3, 1877		9. AGE (In years last birthday) 83 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Carpenter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME Cyrus Keiser			14. MOTHER'S MAIDEN NAME Elizabeth Sweeter		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		INFORMANT Address Louise P. Keiser-Item # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary atherosclerosis DUE TO (c) Generalized atherosclerosis					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Bethesda, Md.	(County)	(State)
21. I certify that I attended the deceased from 5/10 , 19 60 , to 6/30 , 19 60 , that I last saw the deceased alive on 6/29/60 , 19 60 , and that death occurred at 10 A. M., from the causes and on the date stated above ADDRESS (Street, city or town, state) Bethesda, Md. DATE SIGNED 7/1/60 ACTUAL SIGNATURE W. T. Joyce M.D. PHYSICIAN'S NAME (Type) W. T. Joyce 8106 Maple Ridge Rd., Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/2/60	22c. NAME OF CEMETERY OR CREMATORY Mt. Zion	22d. LOCATION (City, town, or county) (State) Bethesda, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler ADDRESS 1331 E. Montg. Ave. Rockville, Md.			24a. REC'D BY REGISTRAR DATE 5 '60	24b. REGISTRAR'S SIGNATURE Carlton S. Kraus	

HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (11)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07090

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 5 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS Rt. #2, Box 115	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harold Middle Bruce Last KILMER III		4. DATE OF DEATH Month June Day 15 Year 19 60	
5 SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-15-60
9. AGE (in years lost birthday) yrs. 14		IF UNDER 1 YEAR Months 5 Days 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Maryland - Ches. Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harold Bruce KILMER, JR.		14. MOTHER'S MAIDEN NAME Audrey Jean BLACKBURN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (F) Harold B. Kilmer, Jr., same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) NEONATAL ATELECTASIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) IMMATURITY DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from June 15, 1960 to June 15, 1960 , that (1) (we) last saw the deceased alive on June 15, 1960 , and that death occurred at 8:55 PM , from the causes and on the date stated above.			
22a. SIGNATURE Fred W. Grello		22b. DATE SIGNED 6-16-60	
22c. PHYSICIAN'S NAME (Type) Fred W. GRELLO, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-20-60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co., 3072 M St., NW, Washington, DC		25a. REC'D BY REGISTRAR JUN 20 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

2066191XVI



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

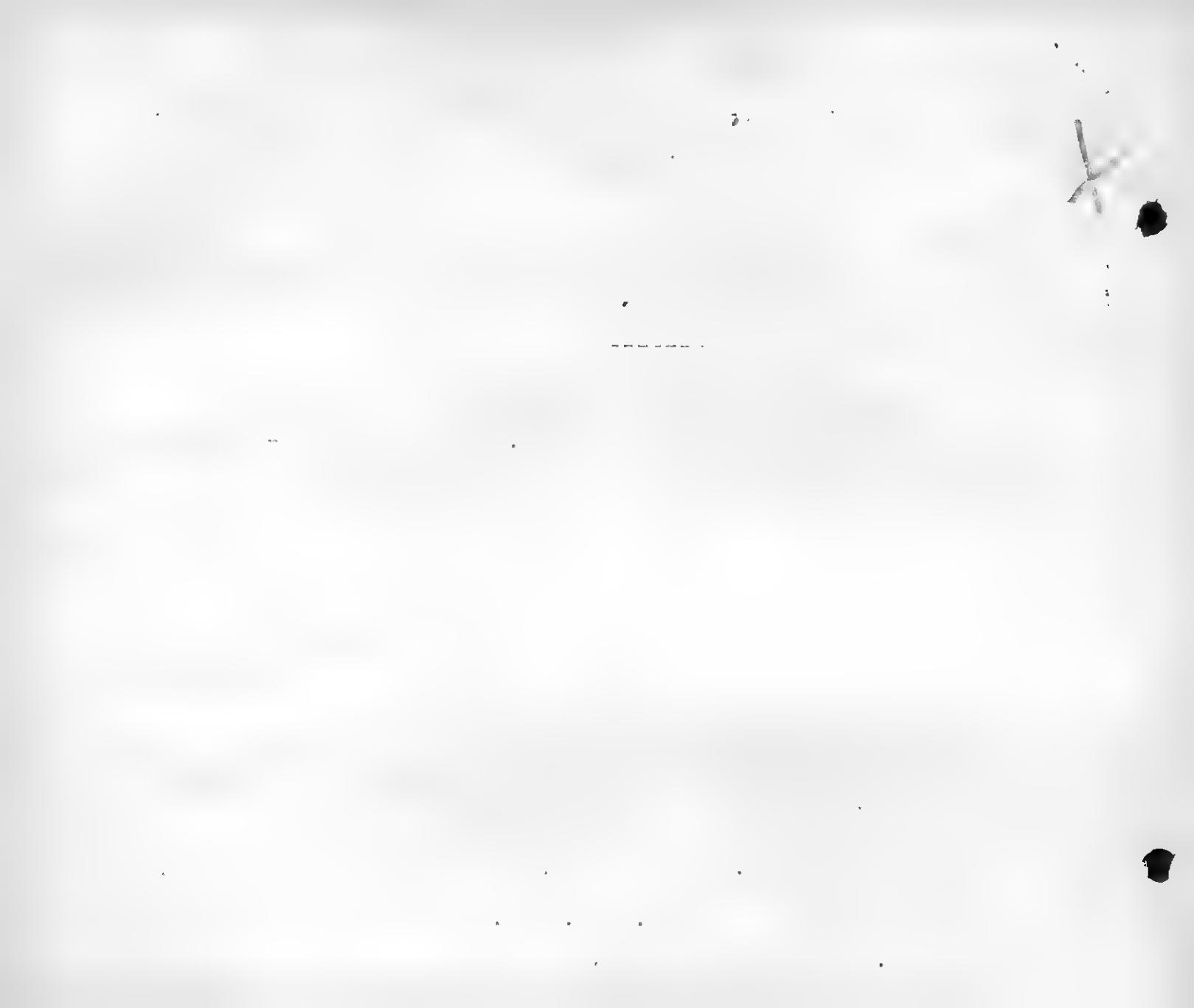
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7088

CERTIFICATE OF DEATH

07091

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 10 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION #8 Sedgewick Lane		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
3. NAME OF DECEASED (Type or print) First Anna Middle Daisy Last King		4. DATE OF DEATH Month June Day 1 Year 19 60	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12/22/1880
9 AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 5 Days 9	IF UNDER 24 HRS Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	11 BIRTHPLACE (State or foreign country) Ohio
12 CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME Peter Wright	
14. MOTHER'S MAIDEN NAME Dugan		15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Mrs. Pauline Neville-daughter-same 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 790.1 IMMEDIATE CAUSE (a) Inanition DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from Dec 3 19 58 to May 30 19 60 that (I) (we) last saw the deceased alive on May 30 19 60 , and that death occurred at 11:30AM June 1, 1960 from the causes and on the date stated above.			
22a SIGNATURE Alfred S. Norton M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b DATE SIGNED 6/1/60	
22c PHYSICIAN'S NAME (Type) Alfred S. Norton M.D.		22d. ADDRESS 4711 Highland Ave. Bethesda, Md.	
23a BURIAL CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 6/4/60	23c NAME OF CEMETERY OR CREMATORY Wash. Nat. Mem. Park	23d. LOCATION (City, town, or county) (State) Suitland, Maryland
24 FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland		25a REC'D BY REGISTRAR DATE JUN 8 '60 25b REGISTRAR'S SIGNATURE Christina L. Hume	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 1 Film G2645 6-20-60 et
CERTIFICATE OF DEATH

07092
Reg. Dist. No.

7146

1 PLACE OF DEATH a. COUNTY Montg MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Montg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Peelville. Rural		c. LENGTH OF STAY IN 1b 3Mo	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 6717 Cedar Ave. Gaithersburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Partnership Nursing Home		d. STREET ADDRESS Maryland	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Lillian Middle Gartrude Last King		4. DATE OF DEATH Month June Day 13 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 24-1887
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR: Months 2 Days 19 IF UNDER 24 HRS: Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY HouseKeeping	
11. BIRTHPLACE (State or foreign country) Montg, Co. Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James Larman		14. MOTHER'S MAIDEN NAME Elizabeth M Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16 SOCIAL SECURITY NO. INFORMANT Anna M. MorningStar. Dickerson-Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Anemia, Secondary, Chronic Blood Loss 581.0 DUE TO Rupture of Varices of Esophagus Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Cirrhosis of liver (c) 		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 3 weeks 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1950 to 13 June 1960 , that I last saw the deceased alive on 13 June 1960 , and that death occurred at 2:55 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Barnesville, Md. DATE SIGNED 13 June 60 ACTUAL SIGNATURE Gordon M. Smith M.D. PHYSICIAN'S NAME (Type) Gordon M. Smith			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-15-60	
22c. NAME OF CEMETERY OR CREMATORY St Rose.		22d. LOCATION (City, town, or county) (State) Clopper. Maryland	
23 FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. Gaithersburg. Md.		24a. REC'D BY REGISTRAR DATE JUN 15 60	
24b. REGISTRAR'S SIGNATURE William S. Turner			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

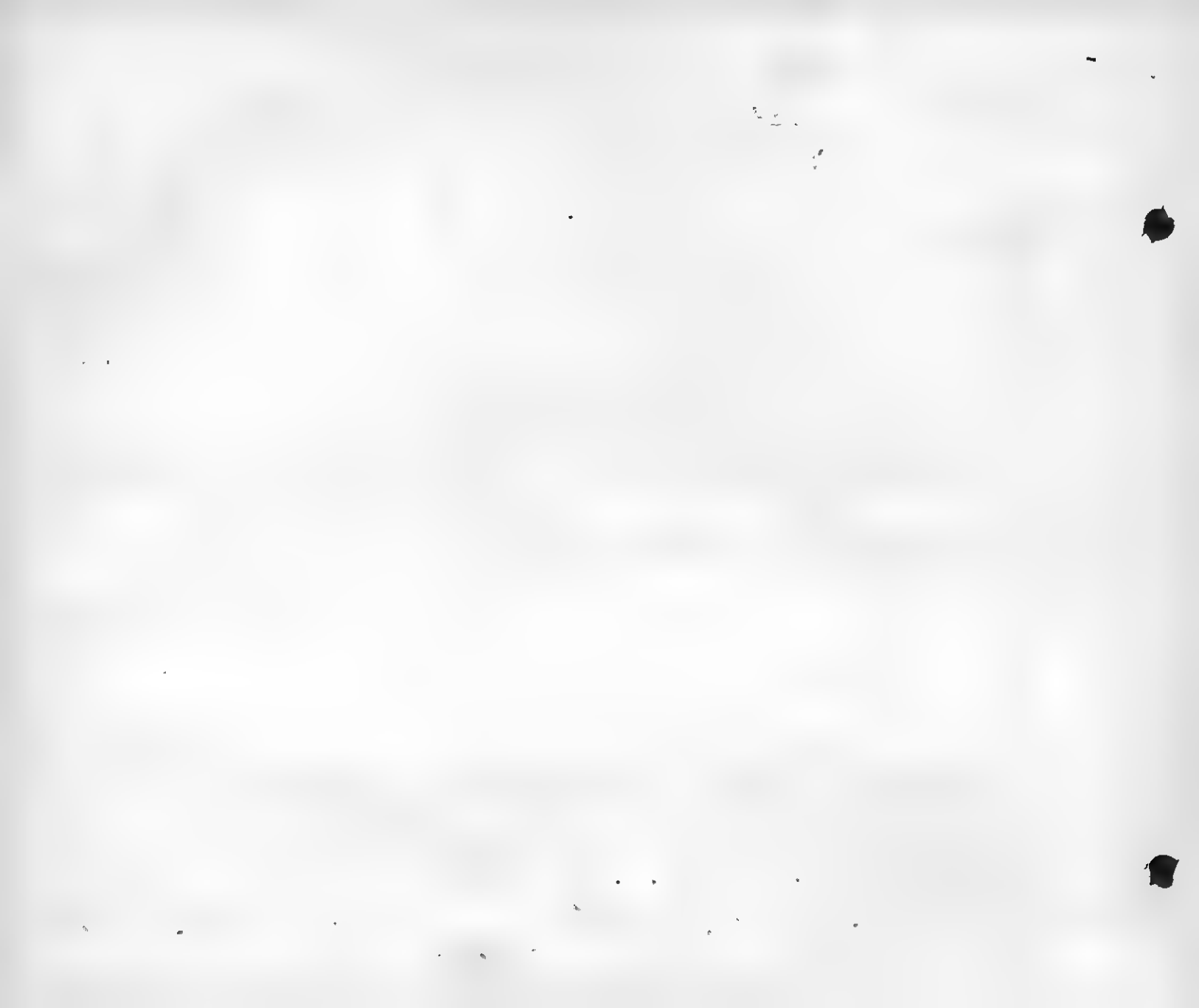
07093
Reg. Dist. No.

7147

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>75x</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	c. LENGTH OF STAY IN Tb <u>70 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mount Morris</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		d. STREET ADDRESS <u>Box 262</u>	
3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>Scott</u> Last <u>King</u>		4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 23, 1919</u>
9. AGE (In years last birthday) <u>41</u> yrs		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Paul King</u>		14. MOTHER'S MAIDEN NAME <u>Jeanne Hickman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda 14, Maryland</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> <u>195.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <u>Pinealoma brain tumor</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21. I certify that I attended the deceased from <u>March 26</u> , 19 <u>60</u> , to <u>June 4</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 1</u> , 19 <u>60</u> , and that death occurred at <u>6:15 P</u> .M, from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		DATE SIGNED <u>6/5/60</u>
PHYSICIAN'S NAME (Type) <u>FRANCIS L. MERRITT, M. D.</u>		<u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-7-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Summit</u>
22d. LOCATION (City, town, or county) <u>Mount Morris Pa.</u>		(State) <u> </u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		24. REC'D BY REGISTRAR <u> </u> DATE <u>JUN 8 60</u>
ADDRESS <u>7557 The Ave. 2nd</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

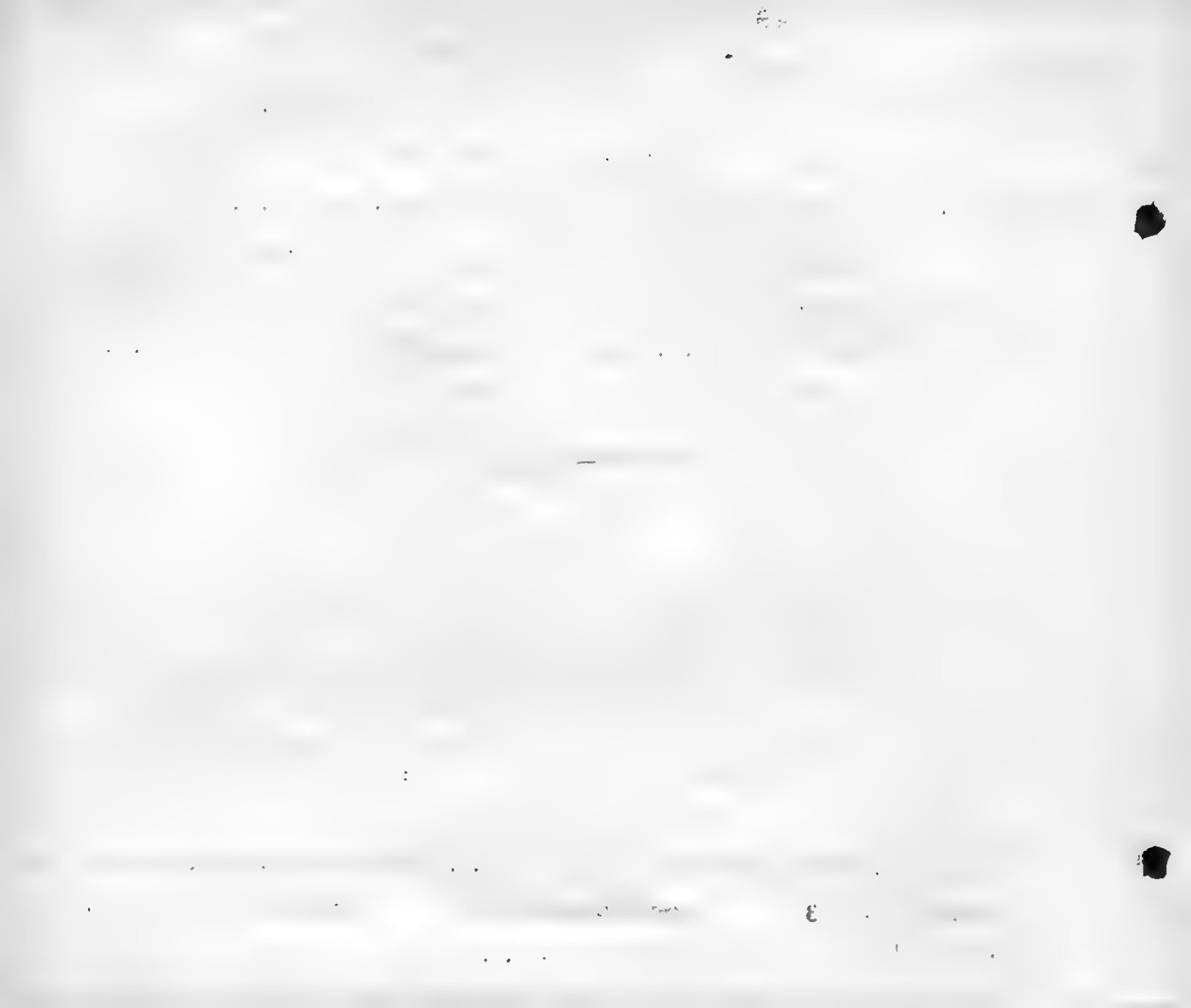
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07094

7148

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington, D.C.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital		d. STREET ADDRESS 2311 Conn. Ave. N.W.		
3. NAME OF DECEASED (Type or print) First Dudley Wright Middle KNOX Last		4. DATE OF DEATH Month JUNE Day 11 Year 19 60		
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 June 1877	
9. AGE (In years last birthday) yrs 82		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		
11. BIRTHPLACE (State or foreign country) WASHINGTON		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Thomas T. KNOX		14. MOTHER'S MAIDEN NAME Cornilla GRASSON		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 1922		
17. INFORMANT HOSP. RECORDS		Address		
18. CAUSE OF DEATH [Enter only one cause per line for Part I and Part II] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of bladder DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastasis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			INTERVAL BETWEEN ONSET AND DEATH 5 yr.	
21. I certify that (I) (this hospital) attended the deceased from April 20 19 60 to June 11 19 60 , that (I) (we) last saw the deceased alive on June 10 19 60 and that death occurred at 6:45 AM , from the causes and on the date stated above			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
22a. SIGNATURE Richard E. Akers M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 6-11-60		
22c. PHYSICIAN'S NAME (Type) Richard E. AKERS LT MC USN		22d. ADDRESS U.S. Naval Hospital, NNMC, Bethesda, Md.		
23a. BURIAL CREMATION, REMOVAL (Specify) Cremat. 6-13-60		23b. DATE THEREOF 6-13-60		
23c. NAME OF CEMETERY OR REMOVAL (Specify) Cedar Hill Cemetery		23d. LOCATION (City or town) (County) (State) Suitland Md.		
24. FUNERAL DIRECTOR'S NAME J. GAWLER'S & SON		ADDRESS 1756 Pennsylvania Ave. N.W. WDC		
25a. REC'D BY REGISTRAR JUN 14 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kneiss		



7149

CERTIFICATE OF DEATH

07095

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Res dence before adm ssion) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>FAIRLAND NURSING Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>KORNHAUSER</u> Last <u>KORNHAUSER</u>		4. DATE OF DEATH Month <u>6</u> Day <u>6</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 10-1892</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>18</u> Hours <u>18</u> Min. <u>18</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New York</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Max Zucker</u>		14. MOTHER'S MAIDEN NAME <u>MARY STERNHEIM</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>INFORMANT</u> Address <u>Nursing Home Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Angiopathic Latent Sclerosis</u> DUE TO <u>200.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>200.1</u> DUE TO (c) <u>200.1</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>200.1</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 1960</u> , to <u>June 6, 1960</u> , that I last saw the deceased alive on <u>June 4, 1960</u> , and that death occurred at <u>11:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Boris Rabkin</u>		ADDRESS (Street, city or town, state) <u>1019 University Boulevard</u> DATE SIGNED <u>6/6/60</u>	
PHYSICIAN'S NAME (Type) <u>BORIS RABKIN, M.D.</u>		<u>Silver Spring Maryland</u>	
22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/9/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New York, N.Y.</u>	22d. LOCATION (City, town, or county) (State) <u>New York</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Nangansky & Sons</u> ADDRESS <u>3501-14th St. N.W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 8 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hays</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7150

CERTIFICATE OF DEATH

07096

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>TURKEY</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>12 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ankara</u>	
3. NAME OF DECEASED (Type or print) First <u>Adil</u> Middle <u>(None)</u> Last <u>Kursad</u>		d. STREET ADDRESS <u>Evkaf Apartment 2, Kapi # 10</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 1, 1914</u>	
9. AGE (In years last birthday) <u>46</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>	
11. BIRTHPLACE (State or foreign country) <u>Turkey</u>		12. CITIZEN OF WHAT COUNTRY? <u>Turkey</u>	
13. FATHER'S NAME <u>Akif Kursad</u>		14. MOTHER'S MAIDEN NAME <u>Fatma Eren</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Mitral insufficiency</u> DUE TO (c) <u>Rheumatic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>27 years</u> <u>30 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1</u> <u>1960</u> to <u>June 13</u> <u>1960</u> that (I) (we) last saw the deceased alive on <u>June 13</u> <u>1960</u> , and that death occurred at <u>4:30 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE <u>6/18/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. Kent Carney, M.D.</u>		22d. ADDRESS <u>The Clinical Center Maryland</u> <u>National Institutes of Health, Bethesda 14</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/24/60</u>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <u>Ankara, Turkey</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co. Inc. 3072 M. St. N.W.</u>		25a. REC'D BY REGISTRAR <u>DAVEN 20 '60</u>	
ADDRESS <u>Wash. D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7034 CERTIFICATE OF DEATH

Reg. Dist. No.

07097

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 9 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12,208 EDMONT STREET		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
3. NAME OF DECEASED (Type or print) Dorothy M. Landvoigt		4. DATE OF DEATH Month June Day 2 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1914
9. AGE (In years, months, days) 46 yrs		10. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk - Posting Sect. F.B.I., U.S. Gov't.		10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE R. MCGEE		14. MOTHER'S MAIDEN NAME MAE LINQUIST	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT Mr. Carroll D. Landvoigt, 12,208 Edgemont St.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinomatosis involving both lungs and abdominal viscera Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary Carcinoma right breast DUE TO (c) 20 w/o PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 17 w/o INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 0 m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb 10, 1959 to June 2, 1960 , that I last saw the deceased alive on June 1, 1960 , and that death occurred at 5:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10620 Georgia Ave Silver Spring Md DATE SIGNED JUN 2, 1960			
ACTUAL SIGNATURE George L. Ball M.D.		PHYSICIAN'S NAME (Type) George L. Ball	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 6/6/60	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY	22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska		24a. REC'D BY REGISTRAR DATE JUN 9 '60	24b. REGISTRAR'S SIGNATURE Arthur S. House

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7151 CERTIFICATE OF DEATH

07098

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 4 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODBINE		d. STREET ADDRESS ROUTE #2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DAISY Middle IONA Last LEAKINS		4. DATE OF DEATH Month JUNE Day 9 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 23, 1902
9. AGE (in years last birthday) 57 yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JAMES AUTHUR MOXLEY		14. MOTHER'S MAIDEN NAME HATTIE VIRGINIA Easton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT HOSPITAL RECORDS		Address OLNEY, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chemia DUE TO Chronic Nephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chemia DUE TO Chronic Nephritis (c) Chemia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH 3 wks. Yrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/5 4:00 PM to 6/9 6:00 PM , that (I) (we) last saw the deceased alive on 6/9 1960 , and that death occurred on 6/10 1960 M, from the causes and on the date stated above.			
22a. SIGNATURE C. H. Ligon, Md.		22b. DATE SIGNED 6/10/60	
22c. PHYSICIAN'S NAME (Type) C. H. LIGON, MD.		22d. ADDRESS SANDY SPRING, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 12, 1960	
23c. NAME OF CEMETERY OR CREMATORY Pine Grove		23d. LOCATION (City, town, or county) (State) Mt. Airy, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Olin L. Moleworth		25a. REC'D BY REGISTRAR DATE JUN 14 '60	
ADDRESS Damascus, Md.		25b. REGISTRAR'S SIGNATURE Charles L. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7152

07099

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 6 HRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL				d. STREET ADDRESS Rt. 1, Box 69 A			
3. NAME OF DECEASED (Type or print) First Middle Last CONNIE LOUISE LEWIS				4. DATE OF DEATH Month Day Year JUNE 28 19 60			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/21/57	9. AGE (In years last birthday) 2 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME JAMES ALEXANDER LEWIS				14. MOTHER'S MAIDEN NAME CARA GROSS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address HOSPITAL RECORDS, OLNEY, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia 490x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Multiple pulmonary Infarctions (c) Intestinal Obstruction due to Parasites							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/28 19 60 , to 6/28 19 60 , that (I) (we) last saw the deceased alive on 6/28 19 60 and that death occurred at 1 PM , from the causes and on the date stated above							
22a. SIGNATURE A. D. BONIFANT, M. D.				22b. DATE SIGNED 6/28/60			
22c. PHYSICIAN'S NAME (Type) A. D. BONIFANT, M. D.				22d. ADDRESS SANDY SPRING, MARYLAND			
23a. BURIAL, CREMATION, or other disposal (Specify) Burial		23b. DATE THEREOF June 30 1960		23c. NAME OF CEMETERY OR CREMATORY Laytonsville		23d. LOCATION (City, town, or county) (State) Laytonsville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Baker				25a. REC'D BY REGISTRAR DATE JUL 1 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



150

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7153

07101

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
c. LENGTH OF STAY IN 1b 26 yrs.		d. STREET ADDRESS 5120 Manning Dr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5120 Manning Dr.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SIDNEY Middle ELY Last LINDERMAN		4. DATE OF DEATH Month June Day 10 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1903
9. AGE (In years last birthday) 57 yrs		10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Exec. Vice Chairman Retired		12. KIND OF BUSINESS OR INDUSTRY Cast Iron Pressure Pipe Inst.	
13. BIRTHPLACE (State or foreign country) Bethlehem, Penna.		14. CITIZEN OF WHAT COUNTRY? U. S.	
15. FATHER'S NAME Garrett Brodhead Linderman		16. MOTHER'S MAIDEN NAME Jennie Brodhead	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yet no, or unknown) No		18. SOCIAL SECURITY NO. 577-09-0468	
19. INFORMANT Wife		20. Address Mrs. Eugenia Linderman	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute toxic myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Right perinephritic abscess DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 18 hrs unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Birrhosis of liver; hepatic insufficiency		22. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
23a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		23b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Birth	
24a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		24b. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
25a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		25b. (City or town) (County) (State)	
26. I certify that (I) (the hospital) attended the deceased from July 1957 to June 1960 , that (I) (we) last saw the deceased alive on June 8 1960 , and that death occurred at 1 A.M. from the causes and on the date stated above.			
27a. SIGNATURE Robert N. Coale		27b. DATE SIGNED 6/10/60	
28a. PHYSICIAN'S NAME (Type) ROBERT N. COALE		28b. ADDRESS 4630 Montgomery Ave., Bethesda, Md.	
29a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		29b. DATE THEREOF 6-11-60	
29c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		29d. LOCATION (City, town, or county) (State) Prince George Co., Md.	
30. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY,		31. ADDRESS Bethesda, Md.	
32. REC'D BY REGISTRAR DATE JUN 14 '60		33. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

47

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

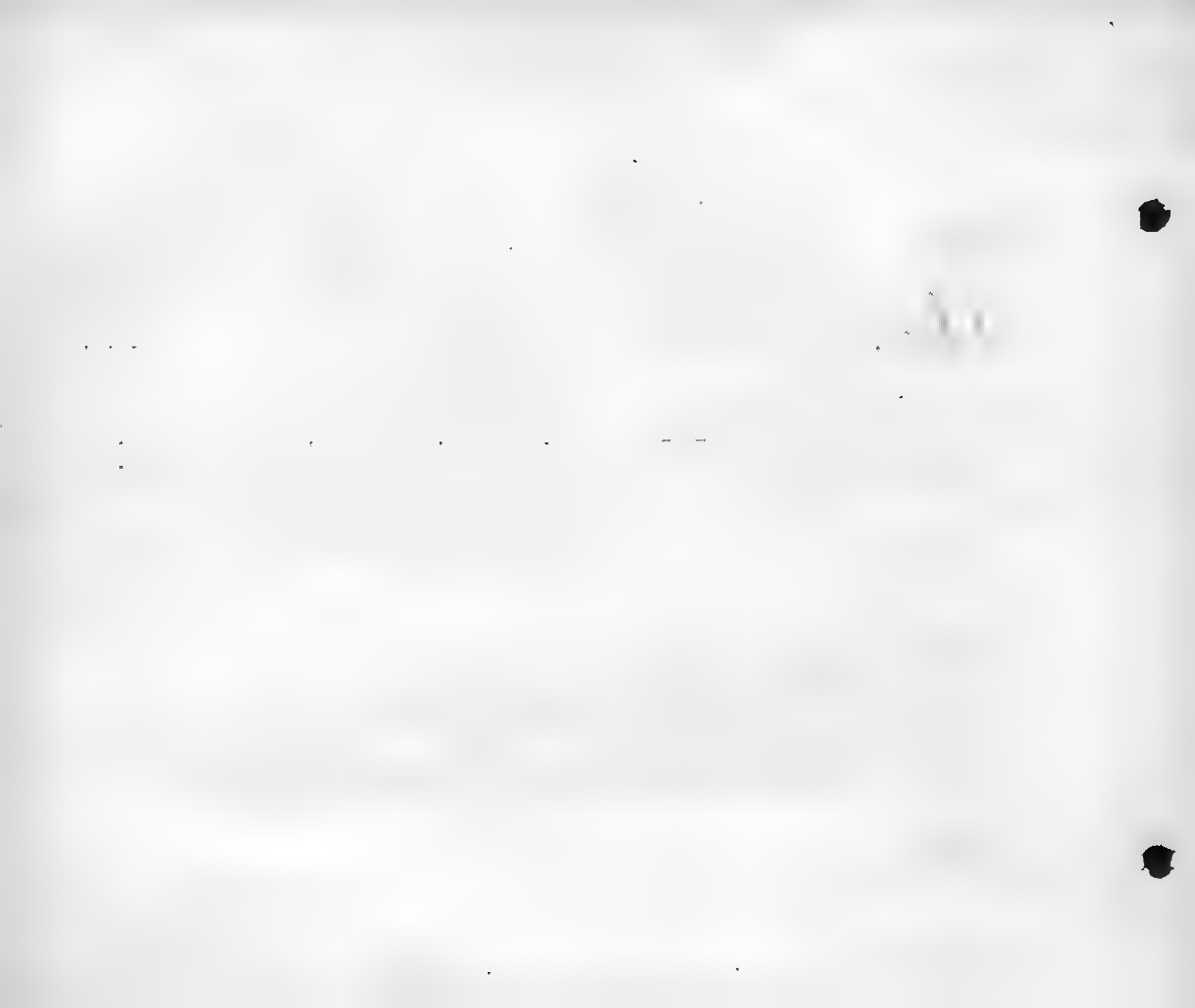
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7035

CERTIFICATE OF DEATH

Reg. Dist. No. 02102

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 9 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8411 11th Ave.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 20 SILVER SPRING	
3. NAME OF DECEASED (Type or print) First SMITH Middle (NMI) Last LINTHICUM		4. DATE OF DEATH Month JUNE Day 20 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/13/93
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) District Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Wilson Steamboat Line	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE F. LINTHICUM		14. MOTHER'S MAIDEN NAME LAURA TABLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 578-14-6584	
17. INFORMANT Mrs. Marie W. Linthicum, 8411 11th Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Silver Spring, Md. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Heart Disease DUE TO 4-5 yrs. (c) Coronary Sclerosis 4-5 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). INTERVAL BETWEEN ONSET AND DEATH 2-3 minutes			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept., 1957 , to June, 1960 , that I last saw the deceased alive on JUNE 20, 1960 , and that death occurred at 8:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7105 Riggs Rd DATE SIGNED 6-20-60 ACTUAL SIGNATURE Robert B. Irey M.D. PHYSICIAN'S NAME (Type) ROBERT B. IREY Hyattsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/23/60	
22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY, INC.		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE JUN 24 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Pines	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7057 CERTIFICATE OF DEATH

07103

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution residence before admission) o STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>YRS</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		18	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7302 HOLLY AVE.</u>		d. STREET ADDRESS <u>7302 HOLLY AVENUE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRED B. LINTON</u>		4. DATE OF DEATH Month Day Year <u>June 19 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 14, 1895</u>
9. AGE (In years last birthday) <u>65</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. U.S. GOVT.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food & Drug Adm.</u>	
11. BIRTHPLACE (State, or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>NOT AVAILABLE</u>		14. MOTHER'S MAIDEN NAME <u>BUFFINGTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS MAYRIE CLEAVER LINTON</u>		Address <u>7302 HOLLY AVE TAKOMA PARK, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>45</u> <u>Congestive Heart Failure</u> DUE TO (b) <u>Arterio-sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 2, 1960</u> , to <u>June 19, 1960</u> , that (I) (we) last saw the deceased alive on <u>June 18, 1960</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>A. B. Little</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>A. B. LITTLE, MD</u>		22d. ADDRESS <u>6911 5th St. N.W.</u>	
23a. BURIAL, CREMATION, REMOVA. (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JUNE 22, '60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>TAYLORS' CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>NR. CENTERTVILLE, WASH. CO., PA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Hume</u>		25a. REC'D BY REGISTRAR <u>DATE JUN 21 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

12

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

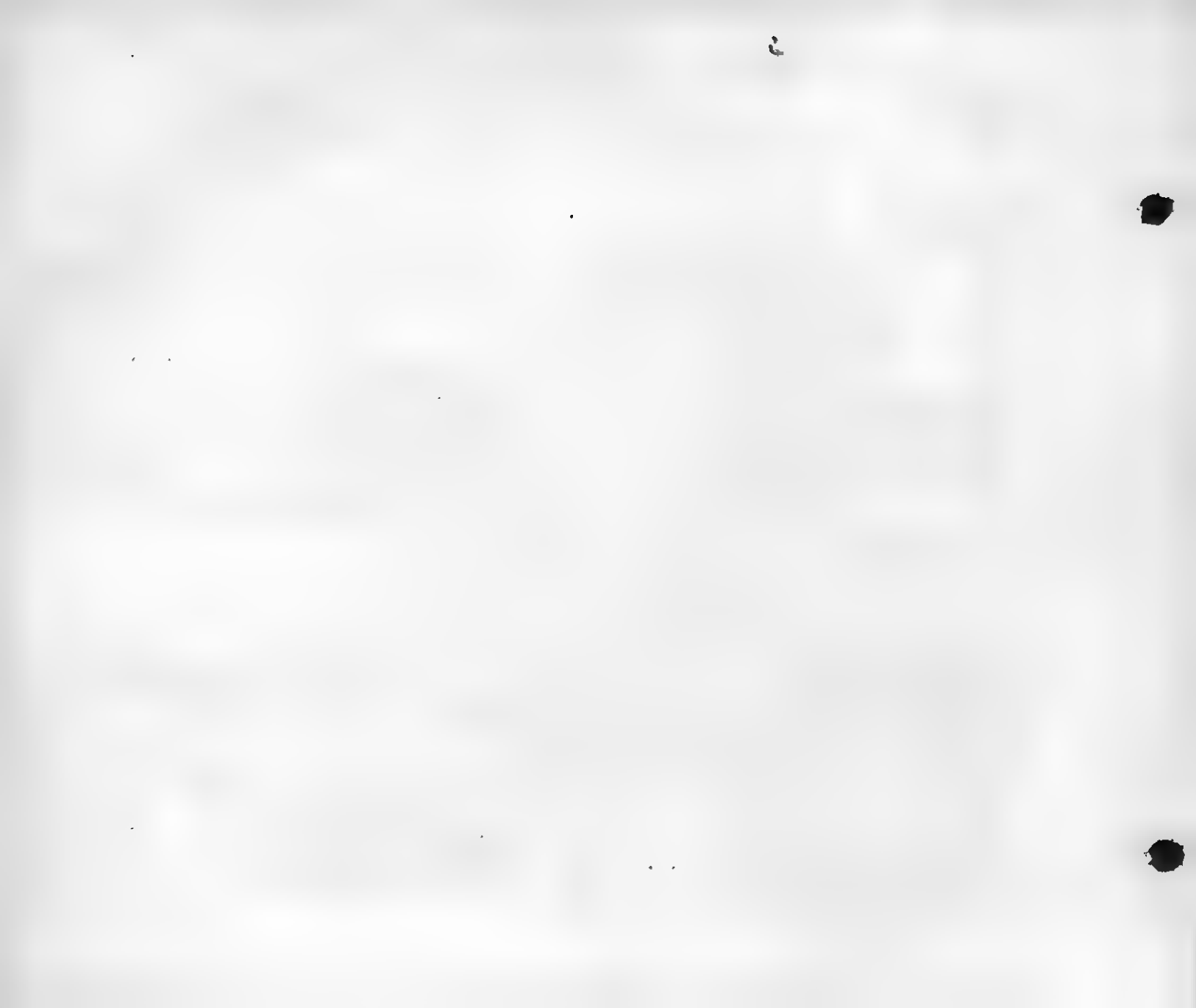
07104

Reg. Dist. No.

7154

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 17 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY Massapequa c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 66 Cedar Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Antonio Middle (None) Last Livorno			4. DATE OF DEATH Month June Day 3 Year 19 60				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1892	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR: Months IF UNDER 24 HRS.: Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clothing Manufacturer		10b. KIND OF BUSINESS OR INDUSTRY Manufacturing		11. BIRTHPLACE (State or foreign country) Italy			
13. FATHER'S NAME (Unknown) Livorno			14. MOTHER'S MAIDEN NAME (Unknown)				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. WW I Unascertainable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ? Cardiac Failure DUE TO (b) Uremia DUE TO (c) Candida Endocarditis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH Minutes 3 Months 6 Months		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from May 17, 1960 , to June 3, 1960 , that I last saw the deceased alive on June 3, 1960 , and that death occurred at 2:25 A. M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED 6-3-60							
ACTUAL SIGNATURE Steven Schenker		M.D. The Clinical Center		National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) STEVEN SCHENKER, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 6-4-1960	22c. NAME OF CEMETERY OR CREMATORY St Johns Cemetery Brooklyn N.Y.	22d. LOCATION (City, town, or county) (State) 71.4				
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co 1400 Chapin St N.W.		ADDRESS St N.W.		24a. RECEIVED BY REGISTRAR DATE JUN 8 '60	24b. REGISTRAR'S SIGNATURE C. J. S. K...		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7058

CERTIFICATE OF DEATH

Reg. Dist. No.

07105

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	c. LENGTH OF STAY IN 1b 5 Hours.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		/d. STREET ADDRESS 1326 Viers Mill Road	
3. NAME OF DECEASED (Type or print) First Middle Last Long		4. DATE OF DEATH Month Day Year June 5 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1960
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs 5
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Charles Leonard Long		14. MOTHER'S MAIDEN NAME Vivian Audrey Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT mother Address SAME
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 5, 1960 to 10:45am, June 5, 1960 , that I last saw the deceased alive on June 5, 1960 , and that death occurred at 10:45am , from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert H. Diamond		ADDRESS (Street, city or town, state) 8224 Georgia Avenue, Silver Spring, Md. DATE SIGNED 6/5/60	
PHYSICIAN'S NAME (Type) Herbert H. Diamond, M.D., 8224 Georgia Avenue, Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation	22b. DATE THEREOF 6-6-60	22c. NAME OF CEMETERY OR CREMATORY Wash. San. & Hosp.	22d. LOCATION (City, town, or county) (State) Takoma Park Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert Hare, M.D., Wash. San. & Hosp.		24a. REC'D BY REGISTRAR DATE JUN 14 '60	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

11



7155

CERTIFICATE OF DEATH

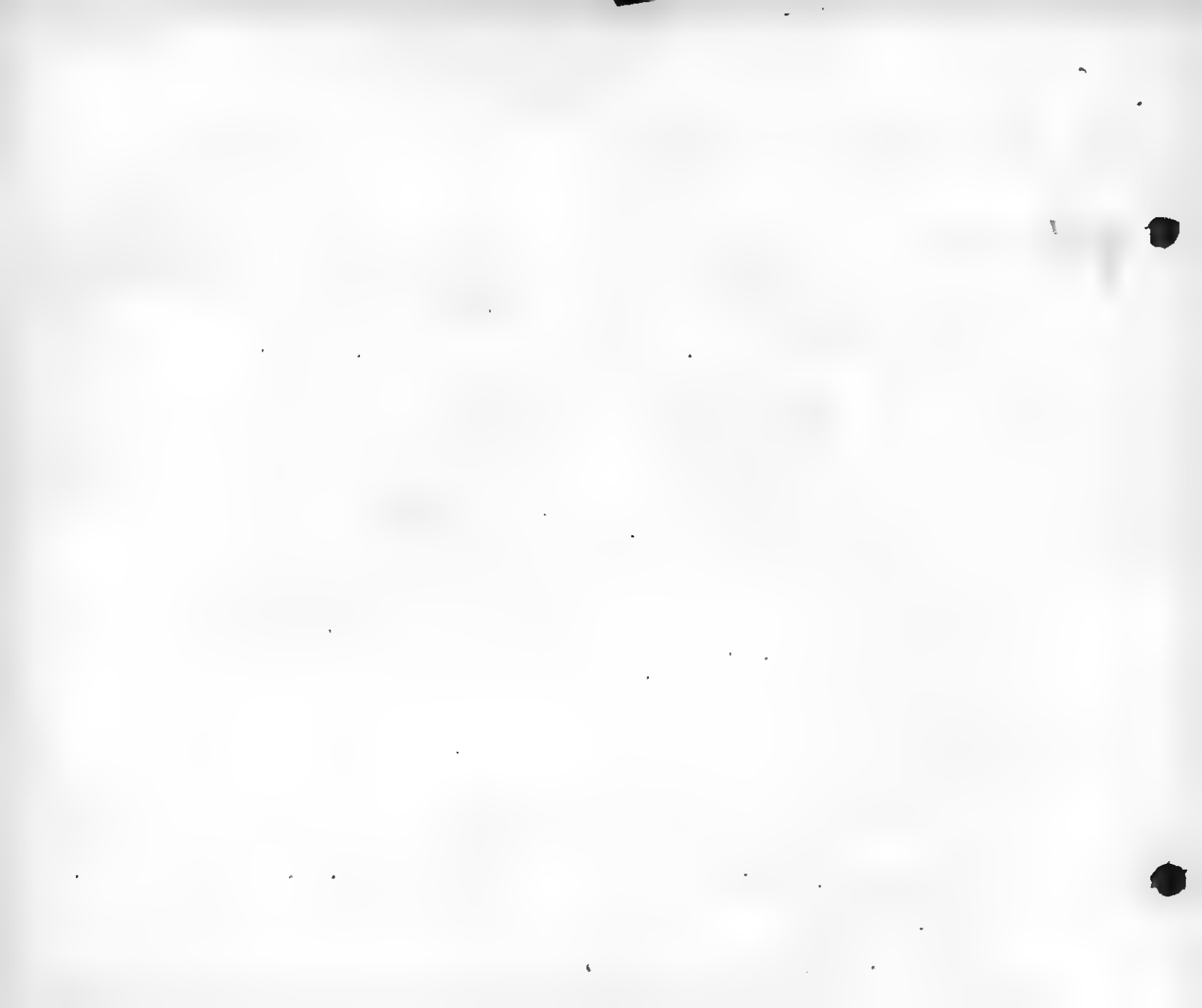
07106

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institut on. Residence before adm ssion) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 16 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. STREET ADDRESS 7653 MacArthur Blvd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mildred Middle Mae Last Lowe				4. DATE OF DEATH Month June Day 12 Year 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR 30, 1914	9. AGE (In years last birthday) 46 yrs	IF UNDER 1 YEAR Months 46 Days 46 Hours 46 Min 46	IF UNDER 24 HRS. Months 46 Days 46 Hours 46 Min 46	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bank Teller		10b. KIND OF BUSINESS OR INDUSTRY Union Trust Co		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank O. Lowe				14. MOTHER'S MAIDEN NAME Martha K. Lynch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		INFORMANT Frank O. Lowe 7653 MacArthur Blvd. Cabin John, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leiomys - Pneumonia of uterus with generalized metastases 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary failure due Lung Metastases							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) none			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 19 59 to 6/12/1960 that I last saw the deceased alive on 6/12 19 60 and that death occurred at 2:45 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1835 Eye St. N. W. Wash. D. C. DATE SIGNED 6/12/60							
ACTUAL SIGNATURE Arch L. Riddick M.D.				PHYSICIAN'S NAME (Type) Arch L. Riddick			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/15/60		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR JUN 15 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7036

CERTIFICATE OF DEATH

Reg. Dist. No. **07107**

1. PLACE OF DEATH a. COUNTY Montgomery Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 20 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2408 Colston Drive		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
		f. STREET ADDRESS 2408 Colston Drive	
3. NAME OF DECEASED (Type or print) John Julian Lyne		4. DATE OF DEATH Month June Day 16 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 29 1871
9. AGE (In years last birthday) yrs 89		10. IF UNDER 1 YEAR Months 4 Days 17	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operated Elevator		10b. KIND OF BUSINESS OR INDUSTRY Grain	
11. BIRTHPLACE (State or foreign country) Jefferson Co. W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Barton Lyne		14. MOTHER'S MAIDEN NAME Mary Ellen Lemen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Susan H. Lyne		18. ADDRESS 2408 Colston Drive Silver Spring Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 10 min. 40 yr.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1952 , 19__ to date , 19__, that I last saw the deceased alive on 1 June , 19 60 , and that death occurred at 11:15 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE John B. Ball		M.D. 7936 Georgetown Rd Bethesda 14 Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 19-60	22c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery	22d. LOCATION (City, town, or county) (State) Shepherdstown W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kline		24a. REC'D BY REGISTRAR DATE JUN 20 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

26.

7156

CERTIFICATE OF DEATH

07108

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE D.C. b. COUNTY 1			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
f. STREET ADDRESS 3747 Huntington St. N.W.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last William F. Maher				4. DATE OF DEATH Month Day Year June 23 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/ 79	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Ireland		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Maher				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO None		INFORMANT Address Dr. H.A. Locke 3747 Huntington St. N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 4301 DUE TO (b) Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Coronary Atherosclerosis						INTERVAL BETWEEN ONSET AND DEATH 24 hours 24 hours years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma Sigmoid Colon, Gas Bacillus Septicemia						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 6-11 , 19 60 , to 6-23 , 19 60 , that I last saw the deceased alive on 6-22 , 19 60 , and that death occurred at 5:40 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5401 Western Ave NW Washington DC DATE SIGNED James E. Nolan							
ACTUAL SIGNATURE James E. Nolan				M.D. 5401 Western Ave NW Washington DC			
PHYSICIAN'S NAME (Type) James E. Nolan							
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 6/25/60		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR JUN 24 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Hays							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page removed from papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

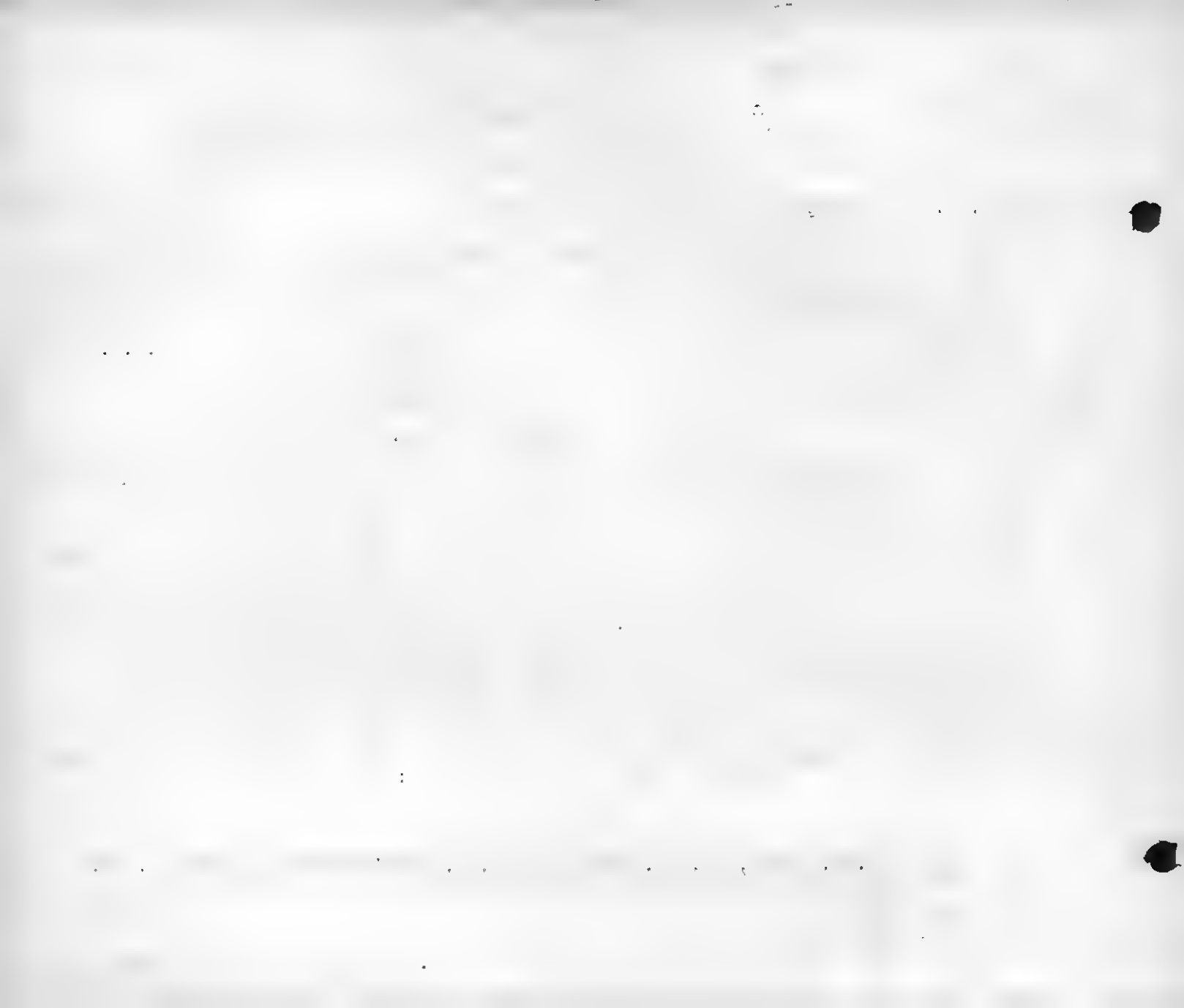
7157

07109

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY St. Mary's ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Great Mills / 8x	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS Box 83	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First John Middle Anthony Last MARRON		4. DATE OF DEATH Month June Day 17 Year 1960	
5 SEX Male	6. COLOR OR RACE Caucasian	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5-1-60
9. AGE (In years last birthday) yrs 1 Months 17 Days 17 Hours 17 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11 BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME John M. MARRON		14. MOTHER'S MAIDEN NAME Maxine JACKSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) - - - - -		16. SOCIAL SECURITY NO None	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain abscess - proteus 342x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 7 days DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Prematurity		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the undersigned) attended the deceased from June 16 1960 to June 17 1960 that (I) (we) last saw the deceased alive on June 16 1960, and that death occurred at 4:40 pm from the causes and on the date stated above			
22a. SIGNATURE G. B. Avery		22b. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
22c. PHYSICIAN'S NAME (Type) G. B. AVERY, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 6-20-60	
23c. NAME OF CEMETERY OR CREMATORY St. Aloysius		23d. LOCATION (City, town, or county) (State) Leonardtwn, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE MATTINGLEY		25a. REC'D BY REGISTRAR June 21 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kenna			

MATTINGLEY FUNERAL HOME LEONARDTOWN, MD

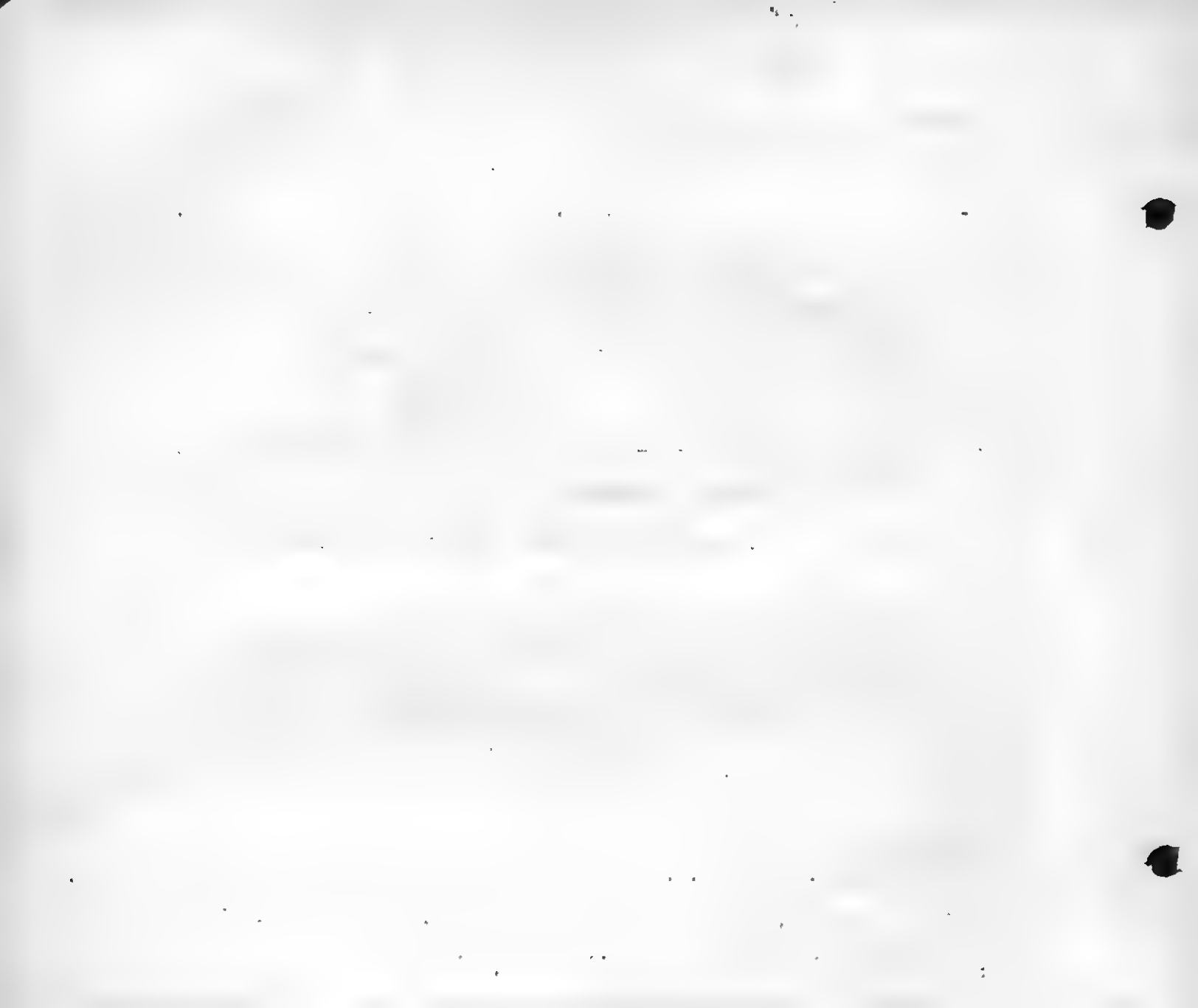
7051342-XV2



7158

VR A15 (4)
ISM 9/59

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>32 days</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Virginia</u>		b. COUNTY <u>Arlington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u>		d. STREET ADDRESS <u>1711 South 26th Street, Apt. 6</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George</u>		First <u>George</u>		Middle <u>Rufus</u>		Last <u>Mason</u>		4. DATE OF DEATH Month <u>June</u>		Day <u>19</u>		Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 31, 1913</u>		9. AGE (In years last birthday) <u>46</u> yrs		IF UNDER 1 YEAR Months <u>46</u>		Days <u>46</u>		Hours <u>46</u>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cafeteria Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George Mason</u>		14. MOTHER'S MAIDEN NAME <u>Freda Kienle</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO <u>263-10-7909</u>	
17. INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda 14, Maryland</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>157X</u> (b) <u>Carcinoma of pancreas with hepatic metastases</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH _____		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____	
20c. TIME OF INJURY Hour a m p. m <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____		(County) _____		(State) _____		21. I certify that (I) (this hospital) attended the deceased from <u>May 18</u> <u>1960</u> , to <u>June 19</u> <u>1960</u> , that (I) (we) lost the deceased alive on <u>June 19</u> <u>1960</u> , and that death occurred at <u>4:30 PM</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Alan B. Retik</u>		22b. PHYSICIAN'S NAME (Type) <u>Alan B. Retik, M.D.</u>		22c. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>		22d. DATE <u>6/20/60</u>		22e. SIGNED <u>Arthur S. Kline</u>		22f. DATE <u>6/20/60</u>		22g. SIGNATURE <u>Arthur S. Kline</u>		22h. DATE <u>6/20/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 22, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		23d. LOCATION (City, town, or county) <u>Arlington, Virginia</u>		23e. (State) <u>Virginia</u>		23f. (County) <u>Arlington</u>		23g. (City or town) <u>Arlington</u>		23h. (State) <u>Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ives Funeral Home, 2847 Wilson Blvd., Arlington, Va.</u>		24a. ADDRESS <u>2847 Wilson Blvd., Arlington, Va.</u>		24b. REC'D BY REGISTRAR <u>DATE JUN 22 '60</u>		24c. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		24d. DATE <u>6/20/60</u>		24e. SIGNATURE <u>Arthur S. Kline</u>		24f. DATE <u>6/20/60</u>		24g. SIGNATURE <u>Arthur S. Kline</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

07111

7159

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. STATE Maryland c. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 3720 Williams Lane			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Henry Middle Agett Last MAY				4. DATE OF DEATH Month June Day 21 Year 1960			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-25-74	
9. AGE (In years last birthday) 85 yrs		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry C. MAY				14. MOTHER'S MAIDEN NAME (unknown) AGETT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 1899 to 1938		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH unknown
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) LOBAR PNEUMONIA.							
DUE TO (b) _____							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a))							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Arteriosclerosis Generalized Fracture (R) humerus.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from June 19 1960 to June 21 1960 that (X) (we) autopsied the deceased alive on June 21 1960 and that death occurred at 6:40AM from the causes and on the date stated above							
22a. SIGNATURE F. J. Dawson II M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 6-21-60	
22c. PHYSICIAN'S NAME (Type) F. J. DAWSON II, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-23-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey				ADDRESS Funeral Home, Bethesda, Md.		25a. REC'D BY REGISTRAR DATE JUN 24 '60	
				25b. REGISTRAR'S SIGNATURE Charles L. Krause			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2. After death, Page 2 of 2 should be filed with the funeral director, may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

51

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07112

7059

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b unknown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 505 Domer Ave. Apt. 203		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) MARGARET First McDONOUGH Middle Last		4. DATE OF DEATH Month 6 - Day 20 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1868
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Patrick Kelly		14. MOTHER'S MAIDEN NAME Margaret O'Brien	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO unknown	
17. INFORMANT Address Takoma Park, Md		18. NAME OF INFORMANT Mary Katherine Long-505 Domer Ave. Apt. 203	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH INSTANT
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10-3 , 19 59 , to 6-20 , 19 60 , that I last saw the deceased alive on 6/19 , 19 60 , and that death occurred at 6A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE R.C. Kirchner		ADDRESS (Street, city or town, state) 6480 N. H. Ave	
PHYSICIAN'S NAME (Type) R.C. KIRCHNER		DATE SIGNED 6/20/60	
22a. BURIAL CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF June 22, 1960	
22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		22d. LOCATION (City, town, or county) (State) Richmond, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.		24a. REC'D BY REGISTRAR DATE JUN 21 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 1 and 2 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07114

7161

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b. <u>23 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4306 Montgomery Ave</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>4306 Montgomery Ave</u>	
3. NAME OF DECEASED (Type or print) <u>William</u> 4. DATE OF DEATH <u>June 13 1960</u> 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>2-20-1901</u> 9. AGE in years (if UNDER 1 YEAR, IF UNDER 24 HRS. (last birthday) Months Days Hours M.n. <u>59</u> yrs. <u>13</u> months <u>13</u> days <u>59</u> hours <u>13</u> min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Int. decorator</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Germany</u> 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13. FATHER'S NAME <u>UNKNOWN</u> 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>217-32-0702</u> 17. INFORMANT <u>Ellen Middy (wife)</u> Address <u>Stem 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>6-13-60</u> Address (Street, city, town, or county) (State)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>6/15/60</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u> 22d. LOCATION (City, town, or country) (State) <u>Rockville, Maryland</u>			
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> Address <u>Bethesda, Maryland</u> 24a. REC'D BY REGISTRAR <u>JUN 15 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VI A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

item 1 filing 264 6-13-60 et

CERTIFICATE OF DEATH

07115

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home</u>		d. STREET ADDRESS <u>1946 Seminary Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>WARD</u> Last <u>MILES</u>		4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 9, 1886</u>
9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>1</u> Hours <u>1</u> Min.	IF UNDER 24 HRS. Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>music teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Ira Wilson Poff</u>		14. MOTHER'S MAIDEN NAME <u>Callie Huff</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>James P. Miles Sr.</u>		<u>1946 Seminary Rd Silver Spring Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive pulmonary embolus</u> DUE TO (b) <u>Myocardial infarction, "recent"</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>2 1/2 months</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>① Malnutrition</u> <u>② Hypothyroidism</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0.1</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 1959</u> to <u>June 1, 1960</u> , that I last saw the deceased alive on <u>May 31, 1960</u> , and that death occurred at <u>8:10 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1834 I Street, N.W., Washington, D.C.</u> DATE SIGNED <u>June 1, 1960</u>			
ACTUAL SIGNATURE <u>George C. Buchanan</u>		M.D. <u>1834 I Street, N.W., Washington, D.C.</u>	
PHYSICIAN'S NAME (Type) <u>George C. Buchanan</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>June 3, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Bluefield, West Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ives Funeral Home, Inc.</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 7 '60</u>	
ADDRESS <u>Arlington, Va.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huff</u>	

25



7162

CERTIFICATE OF DEATH

07116

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>22 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LeDeau Nursing Home</u>		e. STREET ADDRESS <u>10211 Montgomery Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Albert Elias Miller</u>		4. DATE OF DEATH <u>June 8, 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 12, 1876</u>
9. AGE (In years last birthday) <u>83</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11c. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Chauncey D. Miller</u>		14. MOTHER'S MAIDEN NAME <u>Marcia Butler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Miss Helen Miller</u>		Address <u>10211 Montgomery Ave Kensington</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 2, 1960</u> to <u>June 8, 1960</u> , that I last saw the deceased alive on <u>June 8, 1960</u> , and that death occurred at <u>6 p.m.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. H. Stolar</u>		DATE SIGNED <u>June 8, 1960</u>	
PHYSICIAN'S NAME (Type) <u>M. H. Stolar, M.D.</u>		ADDRESS (Street, city or town, state) <u>1801 Eye St. N. W. Washington, D. C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/11/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pughphey</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUN 10 60</u>		24b. REGISTRAR'S SIGNATURE <u>James S. Murrell</u>	

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

41

7060

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PR. George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takem Park</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hospital</u>		d. STREET ADDRESS <u>1215 Valley Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Wells</u> Last <u>Miller</u>		4. DATE OF DEATH Month <u>6</u> Day <u>9</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-14-81</u>
9. AGE (In years last birthday) <u>79</u> yrs		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>9</u> Hours <u>11</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Gardener</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Miller</u>		14. MOTHER'S MAIDEN NAME <u>Mary Montgomery</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hospital Records</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Peritonitis due to</u> DUE TO <u>signed diverticulitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10 days</u> (c) <u>10 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10 days</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-31</u> 19 <u>60</u> , to <u>6-9</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>6-8</u> 19 <u>60</u> , and that death occurred at <u>3:45</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>William Moses M.D.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>William Moses M.D.</u>		22d. ADDRESS <u>1835 Eye St. N.W. Washington, D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-11-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Deak Funeral Home</u>		25a. REC'D BY REG. STRAR <u>JUN 13 '60</u>	
ADDRESS <u>4812 G. Ave. N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

X.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

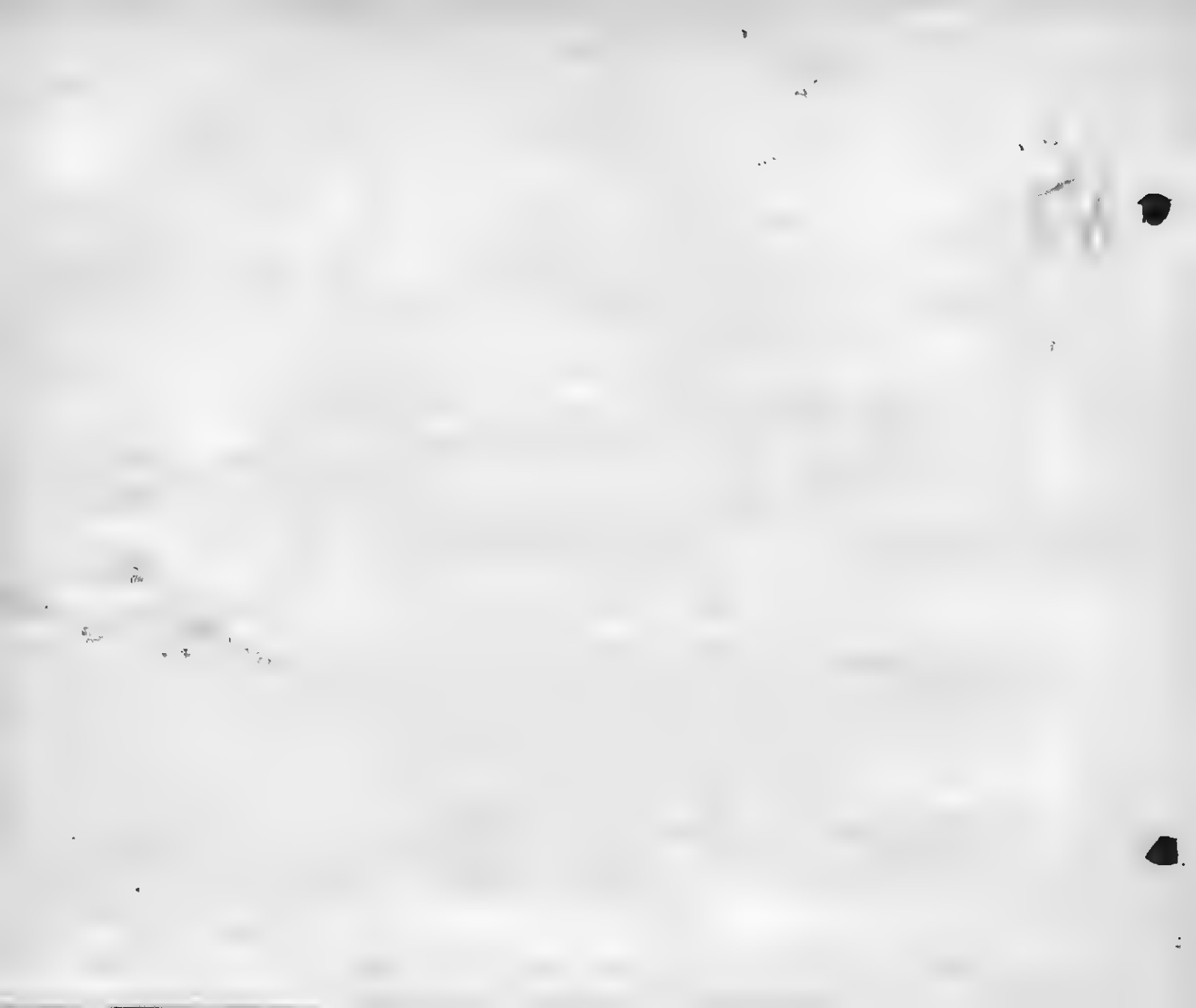
VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07118

7163

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>md</u> b. COUNTY <u>Monty</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Yaithersburg - R-3</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Yaithersburg R-3</u>	
c. LENGTH OF STAY IN 1b <u>life</u>		d. STREET ADDRESS <u>Ripple Ford Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Henry Carlton Mobley</u>		4. DATE OF DEATH <u>June 11 1960</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-11-1896</u>	
9. AGE (in years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Seam.</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew J. Mobley</u>		14. MOTHER'S MAIDEN NAME <u>Hanett A. Selby</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>Hattie Ratcliff - Yaithersburg md R-3</u>	
17. INFORMANT <u>Hattie Ratcliff - Yaithersburg md R-3</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>hypertension</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u> <u>years</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-13-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		22d. LOCATION (City, town, or country) (State) <u>Yaithersburg Md</u>	
23. FUNERAL DIRECTOR <u>Joseph B. Hester</u>		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	
DATE <u>JUN 15 '60</u>			

MEDICAL CERTIFICATION



7164 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

item 9, Illinois, 6-28-60 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>27 hrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaretta</u> Middle <u>Moore</u> Last <u>Moore</u>		4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/3/81</u>
9. AGE (In years last birthday) <u>78 119</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day Worker</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Lewis Sidney</u>	
14. MOTHER'S MAIDEN NAME <u>Not known?</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hoofbeater</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>IX</u> DUE TO (c) <u>16 hrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> Month, Day, Year a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		DATE SIGNED <u>6-13-60</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>6-17-60</u>	<u>St. Rose</u>	<u>Cloppers, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. L. Swender</u>		24. REC'D BY REGISTRAR <u>Rockwell</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
		DATE <u>22 '60</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 3 may be retained for your files. Pages 1, 2, and 3 may be used for a burial-transit permit. Page 4 should be used for a burial-transit permit. or removal.

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form F-43. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7165

07120

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Seneca		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town, Damascus	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac River		d. STREET ADDRESS 27613 Ridge Road	
3. NAME OF DECEASED (Type or print) Donald Monroe Moxley		4. DATE OF DEATH June 6, 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 2/6/1932
9. AGE (In years last birthday) 28 Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Everest M. Moxley		14. MOTHER'S MAIDEN NAME Margaret Bowman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-28-1287	
17. INFORMANT Margaret Welch		Address Item 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Asphyxia		INTERVAL BETWEEN ONSET AND DEATH sudden	
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. drowning			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) Fell or accidentally pushed off barge anchored in Pot. R.			
20c. TIME OF INJURY Month, Day, Year 8:00 p.m. 6/6/60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Potomac R.		20f. (City or town) Seneca (County) Montg. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 9, 1960	
22c. NAME OF CEMETERY OR CREMATORY Montgomery Meth.		22d. LOCATION (City, town, or country) Clagettville, Md.	
23. FUNERAL DIRECTOR Clint L. Mohan		24a. REC'D BY REGISTRAR JUN 9 '60	
ADDRESS Damascus, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7166 **CERTIFICATE OF DEATH** **07121**

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE Florida b COUNTY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c LENGTH OF STAY IN 1b 35 days			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d STREET ADDRESS 920 12th Street, S.			
3 NAME OF DECEASED (Type or print) First William Middle Henry Last MURRAY				4 DATE OF DEATH Month June Day 9 Year 1960			
5 SEX Male	6 COLOR OR RACE Caucasian	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1-4-91	9 AGE (In years last birthday) 69 yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b KIND OF BUSINESS OR INDUSTRY U. S. Navy		11 BIRTHPLACE (State or foreign country) New York		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Ira A. MURRAY				14 MOTHER'S MAIDEN NAME Johanna BURKE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 1912-1942		16. SOCIAL SECURITY NO 011-09-4274		17 INFORMANT Address (S) Mrs. Mary H. Lapham, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastases from carcinoma of Liver DUE TO (b) PRIMARY Carcinoma of Liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (If not, specify) attended the deceased from May 5 1960 to June 9 1960 , that (I) xxx saw the deceased alive on June 9 1960 , and that death occurred at 3:17 PM , from the causes and on the date stated above							
22a SIGNATURE <i>R. G. Muth</i>				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED 6-9-60	
22c PHYSICIAN'S NAME (Type) R. G. MUTH, LT, MC, USN				22d ADDRESS U.S. Naval Hospital, Bethesda, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b DATE THEREOF 6-9-60		23c NAME OF CEMETERY OR CREMATORY Woodbrook Cemetery		23d LOCATION (City, town, or county) (State) Woburn Mass.	
24 FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers & Co.</i> W.W. Chambers & Co., 1400 Chapin St. NW, WashDC				25a REC'D BY REGISTRAR JUN 13 '60		25b REG-STRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



07122

1. PLACE OF DEATH a. COUNTY		MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE		MARYLAND		b. COUNTY		MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		OLNEY		c. LENGTH OF STAY IN lb		24 HOURS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		X		GERMANTOWN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		MONTGOMERY GENERAL HOSPITAL		d. STREET ADDRESS		1		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year	
HARRY		NICHOLSON		NEHOUSE				JUNE		16		1960			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10-21-1881		78		Months		Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?									
FARMER				MARYLAND		U. S. A.									
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME													
Henry N. Nehouse		Anna Hager													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT		Address									
No		213.12.4669		HOSPITAL RECORDS		OLNEY, Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH													
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		177X		DUE TO		1/ANATION, VOMITING + DIARRHEA		48 HOURS							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		DUE TO		CANCER OF PROSTATE		8 YRS.							
(c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)													
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
Hour a. m. p. m.		While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>													
21. I certify that (I) (this hospital) attended the deceased from July 1955, to June 16, 1960, that (I) (we) last saw the deceased alive on June 16, 1960, and that death occurred at 10:25 PM, from the causes and on the date stated above.		22a. SIGNATURE		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS							
G. F. MEADORS JR. M. D.		DAMASCUS, MARYLAND													
23a. BURIAL, CREMATION, or other disposal (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)							
Burial		June 19 60		Salem Methodist		Cedar Grove		Md.							
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Francis H. Barber		Laytonsville, Md.		JUN 21 '60		Arthur S. Thomas									



7082

MARYLAND STATE DEPARTMENT OF HEALTH

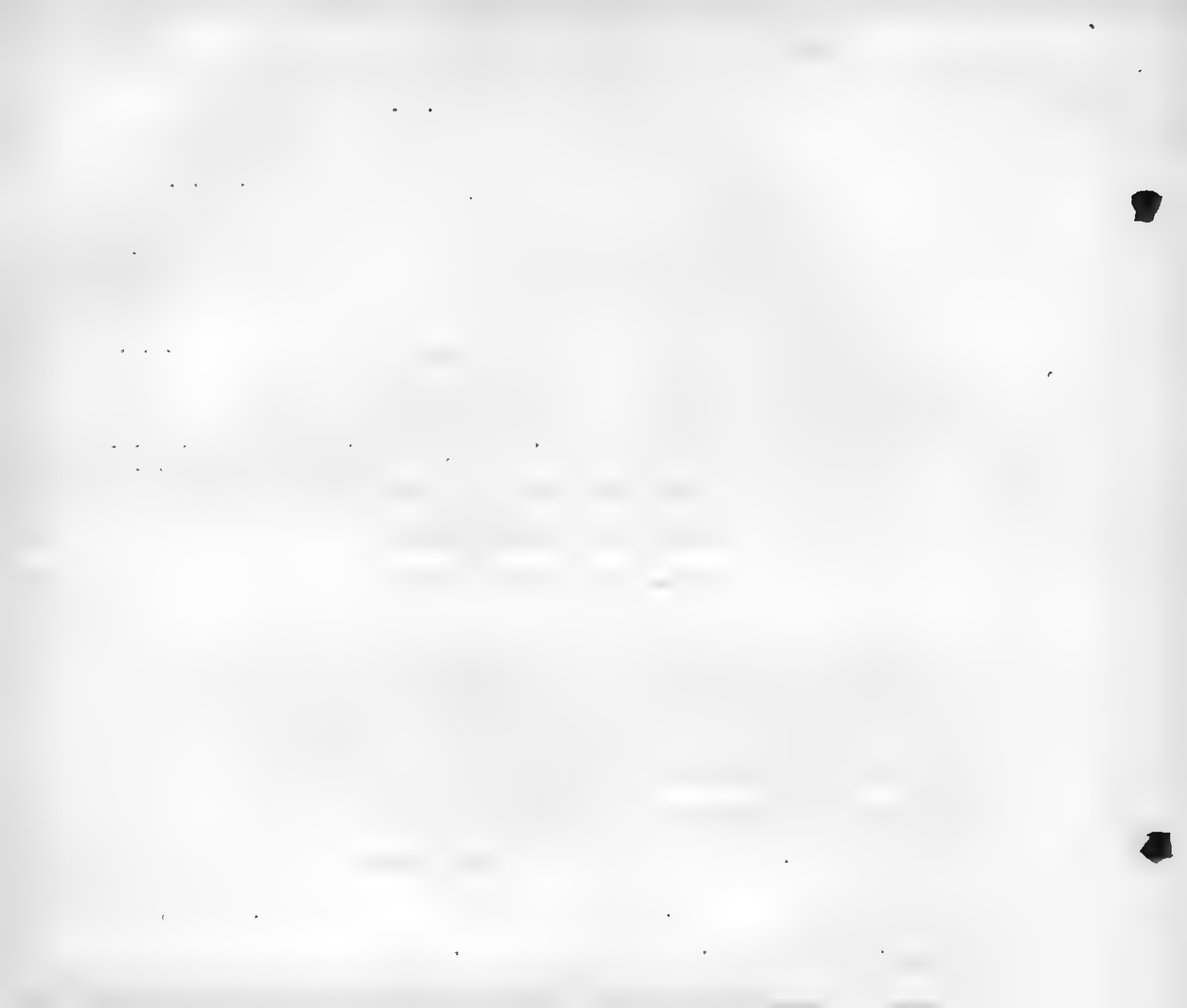
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07123

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) o. STATE <u>D. C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. LENGTH OF STAY IN 1b <u>Since 6/18/60</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Kensington Gardens</u>		d. STREET ADDRESS <u>6615 1st St., N.W.</u> 5800 The Woodlands	
3. NAME OF DECEASED (Type or print) First <u>BERTHA</u> Middle <u>ALICE</u> Last <u>NOLSON</u>		4. DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 13, 1886</u>
9. AGE (In years last birthday) <u>73</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Bridges</u>		14. MOTHER'S MAIDEN NAME <u>Alice Virginia Palmer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mr. Erich Mosettig, 6615 1st St., N.W.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO <u>420-1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary occlusion</u> DUE TO <u>15 minutes</u> (c) <u>coronary arteriosclerosis</u> DUE TO <u>5 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>diabetes mellitus</u> INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 10, 1958</u> to <u>June 22, 1960</u> that (I) (we) last saw the deceased alive on <u>June 20, 1960</u> , and that death occurred at <u>10:35 PM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>Seruch T. Kimble</u>		22b. DATE SIGNED <u>22 June, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Seruch T. Kimble</u>		22d. ADDRESS <u>929 Pershing Drive, Silver Spring, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>6/23/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>		23d. LOCATION (City, town or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PIMPHREY, INC.</u> <u>Raymond H. Ziska</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 27 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be returned by the hospital or attending physician to the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

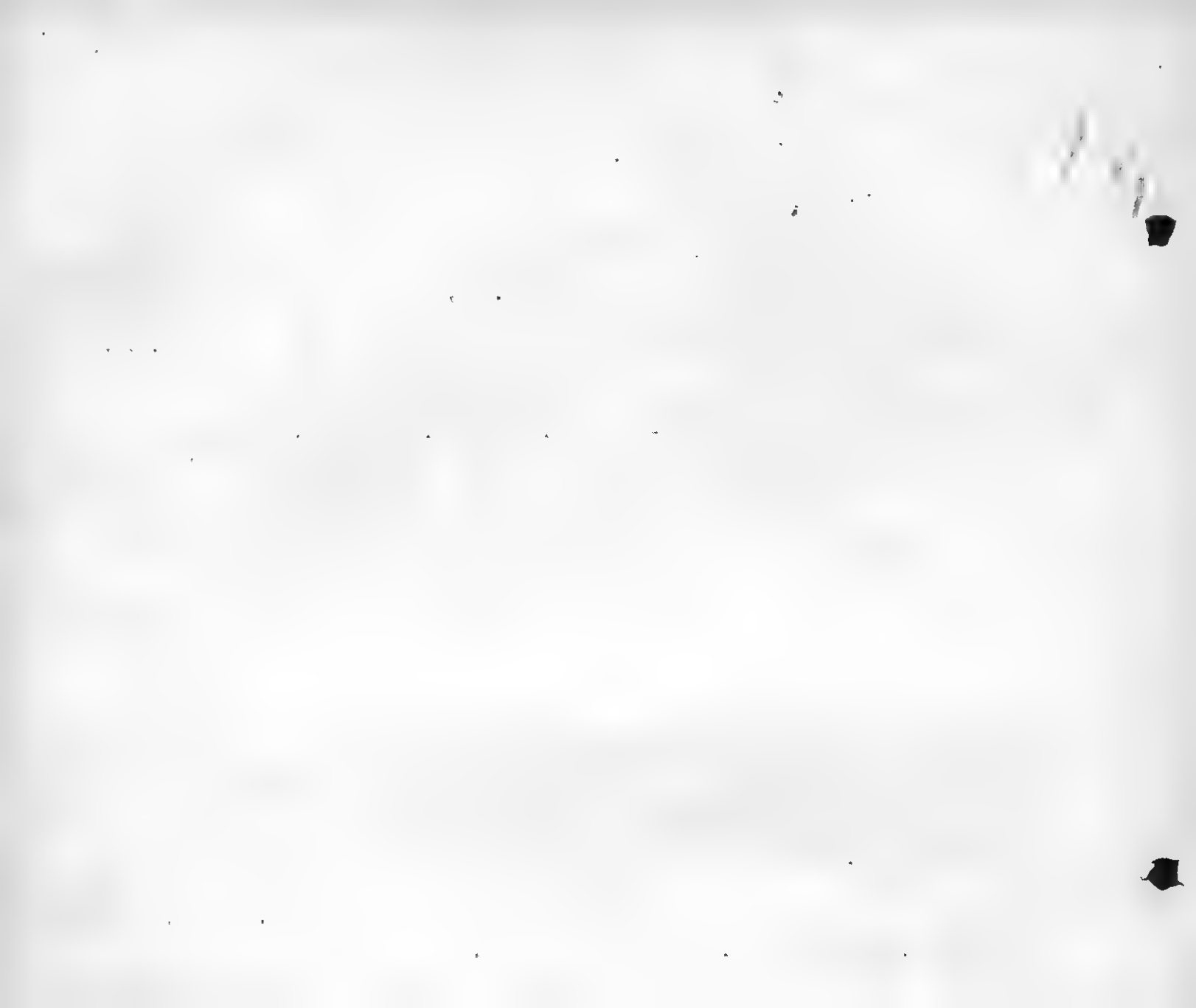
Item 18 Film 265 6-24 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7168

CERTIFICATE OF DEATH

07124

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLESVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLESVILLE	
c. LENGTH OF STAY IN 1b 10 yrs.		d. STREET ADDRESS 812 MIDLAND ROAD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 812 MIDLAND ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First MARGUERITE Middle RUTH Last NOLAN		4 DATE OF DEATH Month JUNE Day 17 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 12, 1915
9 AGE (in years last birthday) 45		10 IF UNDER 1 YEAR Months Days Hours Min.	
11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		11b KIND OF BUSINESS OR INDUSTRY own home	
11c BIRTHPLACE (State or foreign country) PENNSYLVANIA		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD SCOTT		14. MOTHER'S MAIDEN NAME MABEL REED	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16 SOCIAL SECURITY NO 578-12-2497	
17 INFORMANT Mr. Thomas F. Nolan, Jr., 812 Midland Road Colesville, Maryland		18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA of breast DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21 I certify that (I) (the hospital) attended the deceased from Dec. 1959, to June 17, 1960, that (I) (the hospital) saw the deceased alive on June 15, 1960, and that death occurred at 7 AM, from the causes and on the date stated above 22a. SIGNATURE G. Lennard Gold M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED June 17, 1960 22c. PHYSICIAN'S NAME (Type) G. LENNARD GOLD 22d. ADDRESS 8641 Colesville Road, Silver Spr., Md. 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 6/20/60 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY 23d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS WALTER E. PUMPHREY, INC. SILVER SPRING, MD. 25a. REC'D BY REGISTRAR DATE JUN 21 '60 25b. REGISTRAR'S SIGNATURE Arthur L. Hanna	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

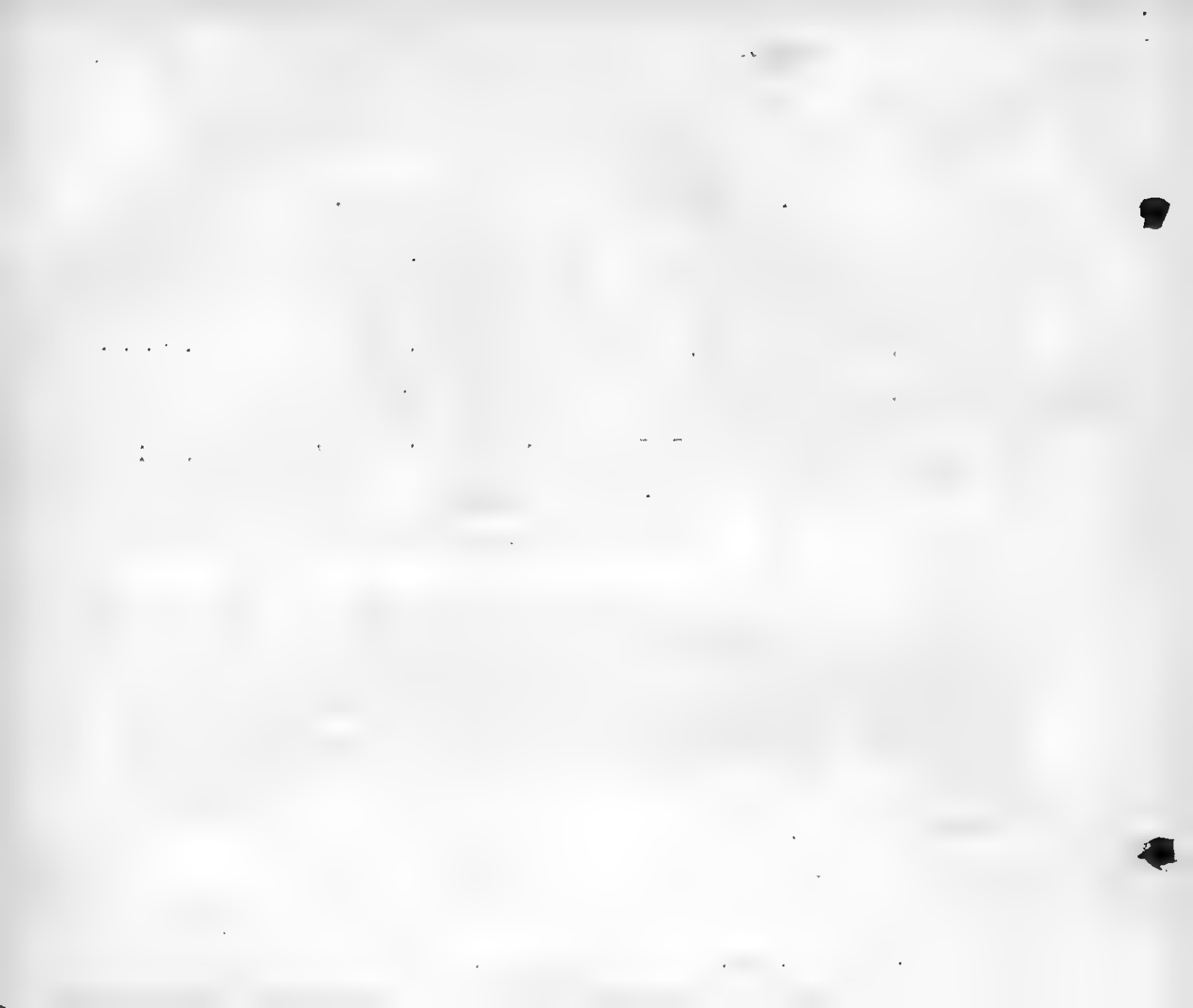
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07125
Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b Since May 1959 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Althea-Woodland Nursing Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS Street address unknown	
3. NAME OF DECEASED (Type or print) First CHARLES Middle ALFRED Last OAKLEY SR.		4. DATE OF DEATH Month JUNE Day 23 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12/6/83
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER, RETIRED		10b. KIND OF BUSINESS OR INDUSTRY PA. RAILROAD	9. AGE (In years last birthday) 76 yrs
11. BIRTHPLACE (State or foreign country) MAGNOLIA, HARFORD COUNTY, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS B. OAKLEY		14. MOTHER'S MAIDEN NAME LAURA JANE GROSS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 717-07-8527	
17. INFORMANT MRS. LOUISE B. MATEER		Address 735 Sligo Ave. Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Arteriosclerosis - generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4 years DUE TO years			INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 6/23/60	
EXAMINER'S NAME (Type) FRANK J. BROSCHEART		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6/27/60	22c. NAME OF CEMETERY OR CREMATORY COKEBURY CEMETERY	22d. LOCATION (City, town, or county) (State) ABBINGDON, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. BUMPNEY, INC.		24a. REC'D BY REGISTRAR JUN 29 '60	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used if needed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7169

CERTIFICATE OF DEATH

07126

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Massachusetts</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>89 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reading</u>		d. STREET ADDRESS <u>56 Wakefield Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Teresa</u> Middle <u>Ann</u> Last <u>O'Brien</u>		4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 6, 1956</u>
9. AGE (In years last birthday) <u>3</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None (Child)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Maurice J. O'Brien</u>	
14. MOTHER'S MAIDEN NAME <u>Mary E. Stapleton</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cystic Fibrosis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>Life</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 18</u> 19 <u>60</u> to <u>June 15</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>June 15</u> 19 <u>60</u> , and that death occurred at <u>5:45 P.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Martin J. Wohl</u> M.D.		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>6-15-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARTIN J. WOHL, M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>June 18</u>		23b. DATE THEREOF <u>June 18</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Agnes</u>		23d. LOCATION (City, town, or county) (State) <u>Albany, New York</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>St. Agnes</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 20 1960</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur B. Kraus</u>		25c. REGISTRAR'S SIGNATURE <u>Arthur B. Kraus</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **07127**

1. PLACE OF DEATH a. COUNTY Montgomery 7089 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 09	
d. NAME OF HOSPITAL (If not in hospital, give street address) 106 Charles Street		d. STREET ADDRESS 106 Charles Street	
3. NAME OF DECEASED (Type or print) HARRIET F. ORRISON		4. DATE OF DEATH June 24, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1902
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY Own Home	
11c. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME George C. Royston		14. MOTHER'S MAIDEN NAME Secy Lawler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 570-20-9047	
17. INFORMANT George L. Orrison-Item 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RENAL FAILURE DUE TO 19.1.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) HEPATIC FAILURE DUE TO (c) CARCINOMA, URINARY BLADDER		INTERVAL BETWEEN ONSET AND DEATH 4 months 6 months 5 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JULY 22, 1953 to JUNE 24, 1960 , that I last saw the deceased alive on JUNE 22, 1960 , and that death occurred at 1:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon S. Rosenberger M.D.		ADDRESS (Street, city or town, state) 310 W. Montgomery Ave. Rockville, MD	
DATE SIGNED June 24, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/27/60	
22c. NAME OF CEMETERY OR CREMATORY Parklawn		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler ADDRESS 1331 E. Montgomery Ave. Rockville, Maryland		24a. REC'D BY REGISTRAR JUN 27 1960	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

TO HOSPITAL BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

19

20

7083

07128

1. PLACE OF DEATH a. COUNTY MONTGOMERY	2. USUAL RESIDENCE (Where deceased lived a. STATE DC	b. COUNTY WASHINGTON	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON	c. LENGTH OF STAY IN 1b 1 week	d. STREET ADDRESS 5924-9th N.W.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last SAMUEL S. PAPER	4. DATE OF DEATH Month Day Year JUNE 25 1960	5. SEX MALE	6. COLOR OR RACE WHITE
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-15-1892	9. AGE (In years lost birth (day) yrs) 68	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life (even if retired)) BAKER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) POLAND	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME LAURENCE PAPER	14. MOTHER'S MAIDEN NAME MOLLIE MINTZ	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. UNKNOWN
17. INFORMANT RACHAEL PAPER	Address 5924-9th NW	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of The Right Lung with metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 6-8 months DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH 6-8 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Carcinoma of bladder; Pulmonary embolism	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) this hospital attended the deceased from 1955 to June 25, 1960 , that (I) we lost saw the deceased alive on 6-25 1960 , and that death occurred at 7:15 PM , from the causes and on the date stated above	22a. SIGNATURE Morris Perry	22b. DATE 6-25-60	22c. PHYSICIAN'S NAME (Type) Morris Perry
22d. ADDRESS 11602 Georgia Ave, Silver Spring, Md.	22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22f. ATTENDING PHYS. <input checked="" type="checkbox"/>	22g. DATE 6-25-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/26/60	23c. NAME OF CEMETERY OR CREMATORY G.W. CEM	23d. LOCATION (City, town, or county) (State) Hyattsville - Md
24. FUNERAL DIRECTOR'S SIGNATURE Edward J. Turner	ADDRESS Hm 4217 4th St NW	25a. REC'D BY REGISTRAR DATE JUN 28 '60	25b. REGISTRAR'S SIGNATURE Carson S. Hanna



7039

CERTIFICATE OF DEATH

07129

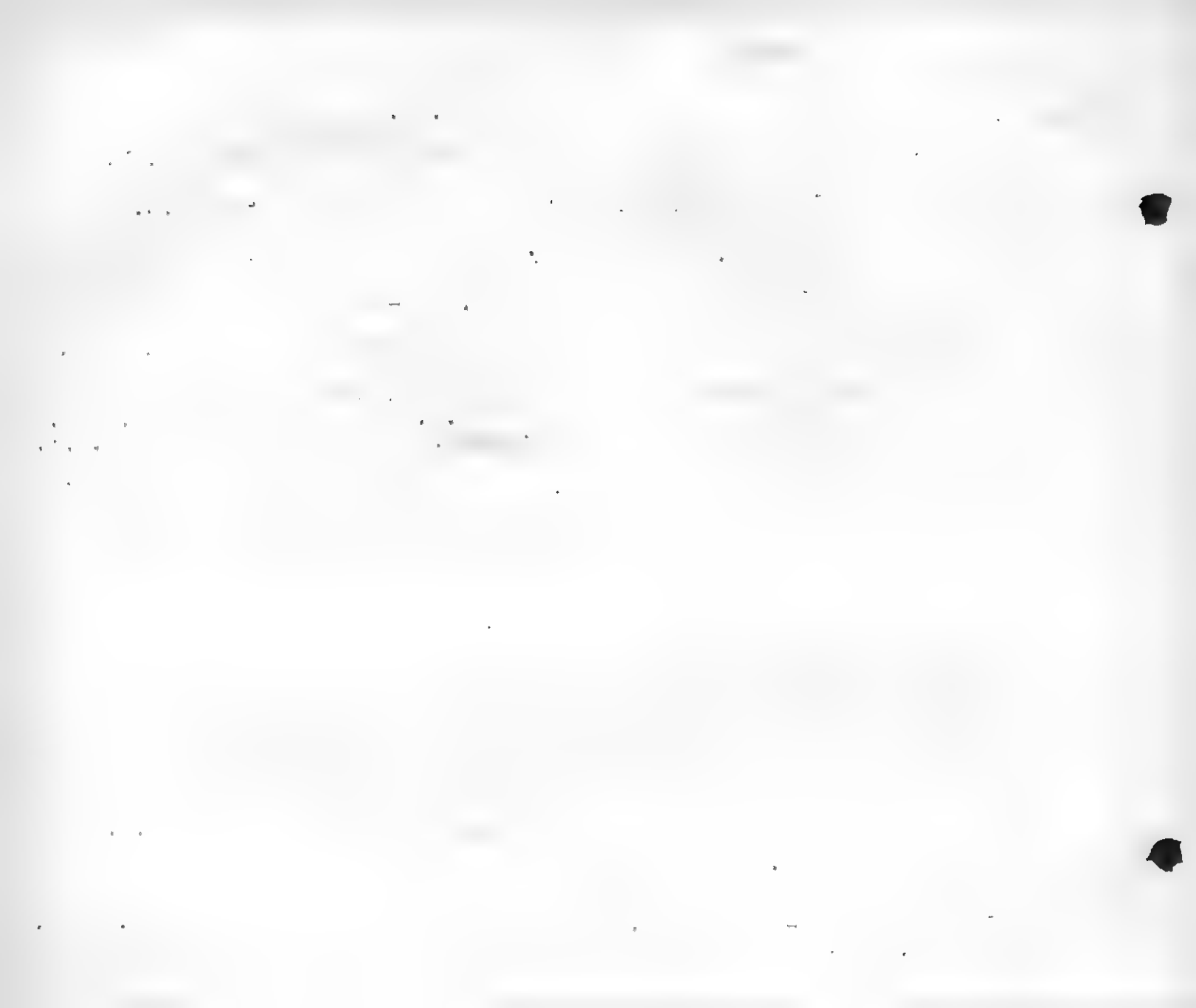
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE D. C. b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LEDEAU GARDENS SANITORIUM				d. STREET ADDRESS 3307 QUESADA STREET N.W.			
3. NAME OF DECEASED (Type or print) First Middle Last ELISE D. PARDEE				4. DATE OF DEATH Month Day Year JUNE 4 19 60			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 23-79	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) LOUISIANA	
13. FATHER'S NAME GASTON DOUSSAN				14. MOTHER'S MAIDEN NAME OLIVA DERBES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT J.P. ABADIE		Address Wash. D.C. 3307 Quesada St. N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Failure DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic Heart Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 48 hrs 12 yrs	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive Coronary Lesions & Uremia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan. 1949 to June 1960 that I last saw the deceased alive on June 4 19 60 , and that death occurred at 11:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Robert G. Taylor				M.D. WASHINGTON CLINIC, WASH. D.C.			
PHYSICIAN'S NAME (Type) ROBERT G. TAYLOR							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6-7-60		22c. NAME OF CEMETERY OR CREMATORY St. Louis #3 Cemetery New Orleans, Louisiana.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Galt				24a. REC'D BY REGISTRAR DATE JUN 7 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Faus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in an event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7170

CERTIFICATE OF DEATH

07130

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 31 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INST TUTION The Clinical Center, Bethesda 14, Md.		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Peru b. COUNTY Lima c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1500 d. STREET ADDRESS 190 Daniel Carrion e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Luis Middle Alfonso Last Paz		4 DATE OF DEATH Month June Day 18 Year 1960	
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 14, 1954
9 AGE (In years lost birthday) 5 yrs		IF UNDER 1 YEAR Months 5 Days 5 Hours 5 Min 5	IF UNDER 24 HRS Months 5 Days 5 Hours 5 Min 5
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Peru
12. CITIZEN OF WHAT COUNTRY? Peru		13. FATHER'S NAME Jose Paz	
14. MOTHER'S MAIDEN NAME Pilar Zapata		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No	
16 SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gastrointestinal hemorrhage 214.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Moniliiasis of esophagus and large intestine DUE TO (c) Acute leukemia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe electrolyte imbalance			INTERVAL BETWEEN ONSET AND DEATH 14 days 10 days 10 months
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <input type="checkbox"/>	
20c TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 190 Daniel Carrion
20f (City or town) Lima		(County) Peru	
21 I certify that (I) (this hospital) attended the deceased from May 18, 1960 to June 18, 1960 , that (I) (we) last saw the deceased alive on June 18, 1960 , and that death occurred at 12:45 AM from the causes and on the date stated above.			
22a SIGNATURE Paul J. Schwab		22b DATE SIGNED 6/19/60	
22c PHYSICIAN'S NAME (Type) PAUL J. SCHWAB, M.D.		22d ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF June 25th, 1960	23c NAME OF CEMETERY OR CREMATORY NATIONAL CEMETERY	23d LOCATION (City, town, or county) (State) LIMA, PERU
24 FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co 1400 Chapin St. N.W. Wash., D.C.		25a REC'D BY REGISTRAR DATE JUN 21 '60	
25b REGISTRAR'S SIGNATURE Carlton A. ...			

MEDICAL CERTIFICATION



7061

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>4743</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>3 hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>May</u> Last <u>Perkins</u>				4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-20-84</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>5</u> Hours <u>15</u> Min.	IF UNDER 24 HRS Months <u>7</u> Days <u>5</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Shettle</u>				14. MOTHER'S MAIDEN NAME <u>Eliza I. McComas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-05-6892A</u>		INFORMANT <u>W.S. Hospital Records</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>153.9</u> DUE TO <u>Cancer of Bowel</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 19 1960</u> to <u>June 3 1960</u> , that I last saw the deceased alive on <u>June 2 1960</u> , and that death occurred at <u>11:24 A.M.</u> , from the causes and on the date stated above							
ACTUAL SIGNATURE <u>John N. Andrews</u>				ADDRESS (Street, city or town, state) <u>9601 Colosville Rd Silver Spring Md</u>			
PHYSICIAN'S NAME (Type) <u>John N. Andrews</u>				DATE SIGNED <u>June 3 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/6/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Jaska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 9 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

717 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07132

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo Heights				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 58 Glen Echo Heights			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5401 Wehawken Road				e. STREET ADDRESS 5401 Wehawken Road			
3. NAME OF DECEASED (Type or print) First Noble Middle Fountain Last Peters				4. DATE OF DEATH Month 6 Day 23 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/3/08	
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months 5 Days 15		IF UNDER 24 HRS. Hours 15 Min. 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Crane Op.				10b. KIND OF BUSINESS OR INDUSTRY Navy Gun Fact.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME George F. Peters				14. MOTHER'S MAIDEN NAME Anna Maude Trevey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW 2				16. SOCIAL SECURITY NO. 578-03-7146			
17. INFORMANT Hazel Peters-wife-same 2d				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 976 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bullet wound through skull DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH sudden							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted bullet wound through skull			
20c. TIME OF INJURY Hour 12:30 a. m. 6 m. 23 Day 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Glen Echo Hts Montg. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank J. Broschart</i> EXAMINER'S NAME (Type) Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 6/23/60							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/26/60		22c. NAME OF CEMETERY OR CREMATORY Potomac Church Cem.		22d. LOCATION (City, town, or county) (State) Potomac, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUN 27 '60	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>							

MEDICAL CERTIFICATION

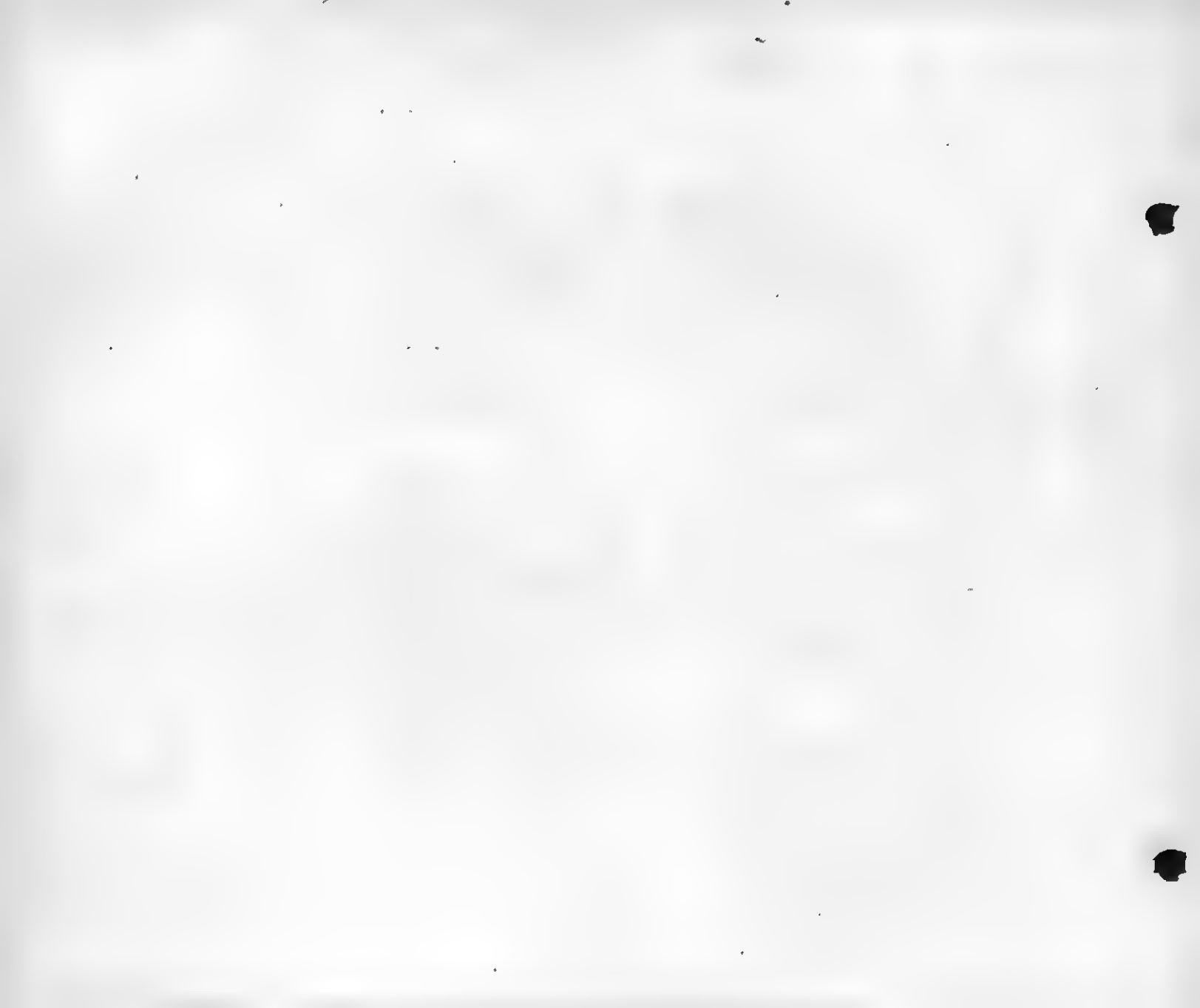
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the Registrar, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

5X

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7084
CERTIFICATE OF DEATH

07133

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN TB 8 Mo. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE D.C. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 511 - C St N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Eugene L. Middle Phillips Last Phillips		4. DATE OF DEATH Month June Day 22 Year 1960	
5 SEX Male	6 COLOR OR RACE Caucasian	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 29, 1880
9. AGE (in years last birthday) 79		IF UNDER 1 YEAR IF UNDER 24 HRS Months 79 Days 79 Hours 79 Min. 79	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Showman	
11 BIRTHPLACE (State or foreign country) D.C.		12 CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Ephriam Phillips		14 MOTHER'S MAIDEN NAME Margaret Higgins	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Records.	
17. INFORMANT Records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO 120.0 Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Heart Failure, Compensated DUE TO 3 Mont (c) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 3 Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from October 29, 1959 to June 22, 1960 , that (I) (we) lost saw the deceased alive on June 22, 1960 , and that death occurred at 6:20 p. from the causes and on the date stated above.		22a. SIGNATURE Robert T. Thibodeau M.D. June 22, 1960	
22b. PHYSICIAN'S NAME (Type) Robert T. Thibodeau, M.D.		22c. ADDRESS 10609 Concord St., Kensington, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-25-60	
23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln		23d. LOCATION (City, town or county) (State) Bladensburg, Md	
24 FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home.		ADDRESS Washington, D.C.	
25a. REC'D BY REGISTRAR JUN 24 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Frank	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR ATS (4)
ISM 9/59

1



X

1

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND																			
7172																			
CERTIFICATE OF DEATH																			
07134																			
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived If institut on. Res dence before admission) a. STATE Maryland b. COUNTY Montgomery														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda					c. LENGTH OF STAY IN 1b 11 Years					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 46 Bethesda									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5407 Roosevelt Street					1. d. STREET ADDRESS 5407 Roosevelt St.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First OTTILIA Middle MARIA Last PHILLIPS					4. DATE OF DEATH Month June Day 3 Year 1960														
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 26, 1866		9. AGE (In years lost birthday) yrs 93		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY Buffalo, New York					11. BIRTHPLACE (State or foreign country) U. S.					12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME John J. Schmitz					14. MOTHER'S MAIDEN NAME Johanna Kirsh														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO None					17. INFORMANT Daughter Mrs. Ruth A. Phillips					Address Same as ITEM # 2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 450.0 DUE TO Myocardial Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis generalized (c)										INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 1953 , 19 to June 3, 1960 ; that (I) (we) last saw the deceased alive on June 19, 1960 , and that death occurred at 12 PM , from the causes and on the date stated above																			
22a. SIGNATURE Alfred S. Norton					M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b. ADDRESS 4711 Highland Ave., Bethesda, Maryland					22c. PHYSICIAN'S NAME (Type) ALFRED S. NORTON					22d. DATE SIGNED 6/3/60				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 6/6/60					23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery					23d. LOCATION (City, town, or county) (State) Fredericksburg, Virginia				
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey					ADDRESS Bethesda, Maryland					25a. REC'D BY REGISTRAR DATE JUN 8 '60					25b. REGISTRAR'S SIGNATURE Arthur L. Hines				

44

7173

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>University Park, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>4304 Claggett Rd. University Park</u>	
3. NAME OF DECEASED (Type or print) <u>Adelaide</u> First <u>C. Pohlen</u> Middle Last		4. DATE OF DEATH Month <u>June</u> Day <u>22</u> , 1960 Year <u>19</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/21/14</u>
9. AGE (In years lost birthday) yrs. <u>46</u>		IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gift Shop</u>	
11. BIRTHPLACE (State or foreign country) <u>Brownsville, Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James J. Fox</u>		14. MOTHER'S MAIDEN NAME <u>Adelaide Celeya</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>—</u>	
INFORMANT <u>Mr s. Frances Sarles</u>		Address <u>4104 Dewmar Ct. Kensington</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO <u>Staphylococcal Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebrospinal fistula + meningitis</u> DUE TO (c) <u>3 weeks</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 1960, to <u>June 22</u> , 1960, that I last saw the deceased alive on <u>June 21</u> , 1960, and that death occurred at <u>6:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1835 E. St NW - Washington DC</u>			
ACTUAL SIGNATURE <u>Frank A. Ashburn</u> M.D.		DATE SIGNED <u>June 22 1960</u>	
PHYSICIAN'S NAME (Type) <u>Washington DC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/25/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	22d. LOCATION (City, town, or county) (State) <u>Wheaton Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 24 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 after death. Page 1
may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7174
CERTIFICATE OF DEATH
07136

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 72 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			d. STREET ADDRESS 5807 Phoenix Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Donald Middle Lee Last Putnam			4. DATE OF DEATH Month June Day 16 Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1925	9. AGE (In years last birthday) 35 yrs	10. IF UNDER 1 YEAR Months 35 Days 35 Hours 35 Min 35
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Illinois	
13. FATHER'S NAME John Putnam			14. MOTHER'S MAIDEN NAME Hazel Guild		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes give war or dates of service) WW II			17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic myelogenous leukemia 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 204.1 DUE TO (c) 204.1					INTERVAL BETWEEN ONSET AND DEATH 20 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 204.1					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1:45 AM	
21. I certify that (I) (this hospital) attended the deceased from April 5, 1960 , to June 16, 1960 , that (I) (we) last saw the deceased alive on June 16, 1960 , and that death occurred on June 16, 1960 from the causes and on the date stated above					
22a. SIGNATURE Emanuel S. Hellman, M.D.		22b. PHYSICIAN'S NAME (Type) Emanuel S. Hellman, M.D.		22c. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/20/60		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR JUN 17 60	
25b. REGISTRAR'S SIGNATURE Robert A. Pumphrey		25c. REGISTRAR'S SIGNATURE Robert A. Pumphrey			

415

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7175

07137

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Utah b. COUNTY Salt Lake	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salt Lake City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		d. STREET ADDRESS 181 Edith Ave.	
3. NAME OF DECEASED (Type or print) Rose Litster Ramussen		4. DATE OF DEATH Month June Day 5 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/30/83
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min. 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Utah	
11. BIRTHPLACE (State or foreign country) Utah		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Litster		14. MOTHER'S MAIDEN NAME J. Cunningham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Dr. Grant Ramussen (Son)		Address 9801 Broadstreet Bethesda Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary insufficiency DUE TO (c) Coronary insufficiency			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Died while undergoing sympathectomy under general anesthesia			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank Brochart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank Brochart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 4-5260	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 6/6/60	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Salt Lake City, Utah	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR JUN 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thoms	

TO DEPARTMENT OF MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please excuse the certificate. If the certificate is not filed, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 4 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07138

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Monty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Cherry Chase</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7311 Somander La</u>				d. STREET ADDRESS <u>7311 Somander La</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hugo</u> Middle <u>Reyer</u> Last <u></u>				4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-2-1892</u>	
9. AGE (In years (last birthday)) <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. (gov.) Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Wis</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Adam Reyner</u>				14. MOTHER'S MAIDEN NAME <u>Emma Reich</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give war or dates of service) <u>WW 1</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Martha H. Reyner</u>		Address <u>Stuen 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in chair</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u></u> o. m. <u></u> p. m. <u></u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		<u>6-26-60</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/29/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>JUN 28 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>William S. H.</u>	

50

7176

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Matthews Nursing Home		e. STREET ADDRESS Box 98	
3. NAME OF DECEASED (Type or print) First BETTY Middle R. Last RICHARDSON		4. DATE OF DEATH Month JUNE Day 4 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/28/1866
9. AGE (In years last birthday) yrs 93		IF UNDER 1 YEAR Months 13 Days 6 Hours Min 	
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Richard Simpson		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Harry E. Richardson-son-same 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive pneumonia 4 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1-week 2 months 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20. inability		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 6, 1958 to 4 June, 1960 that I last saw the deceased alive on 4 June, 1960 , and that death occurred at 8 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Darmanville DATE SIGNED 6/9/60 ACTUAL SIGNATURE John G. Fawcett M.D. P.O. Boyd, Md. PHYSICIAN'S NAME (Type) John G. Fawcett			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/6/60	
22c. NAME OF CEMETERY OR CREMATORY St. Mark's Cemetery		22d. LOCATION (City, town, or county) (State) Highland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE JUN 8 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

X

7040

CERTIFICATE OF DEATH

Reg. Dist. No.

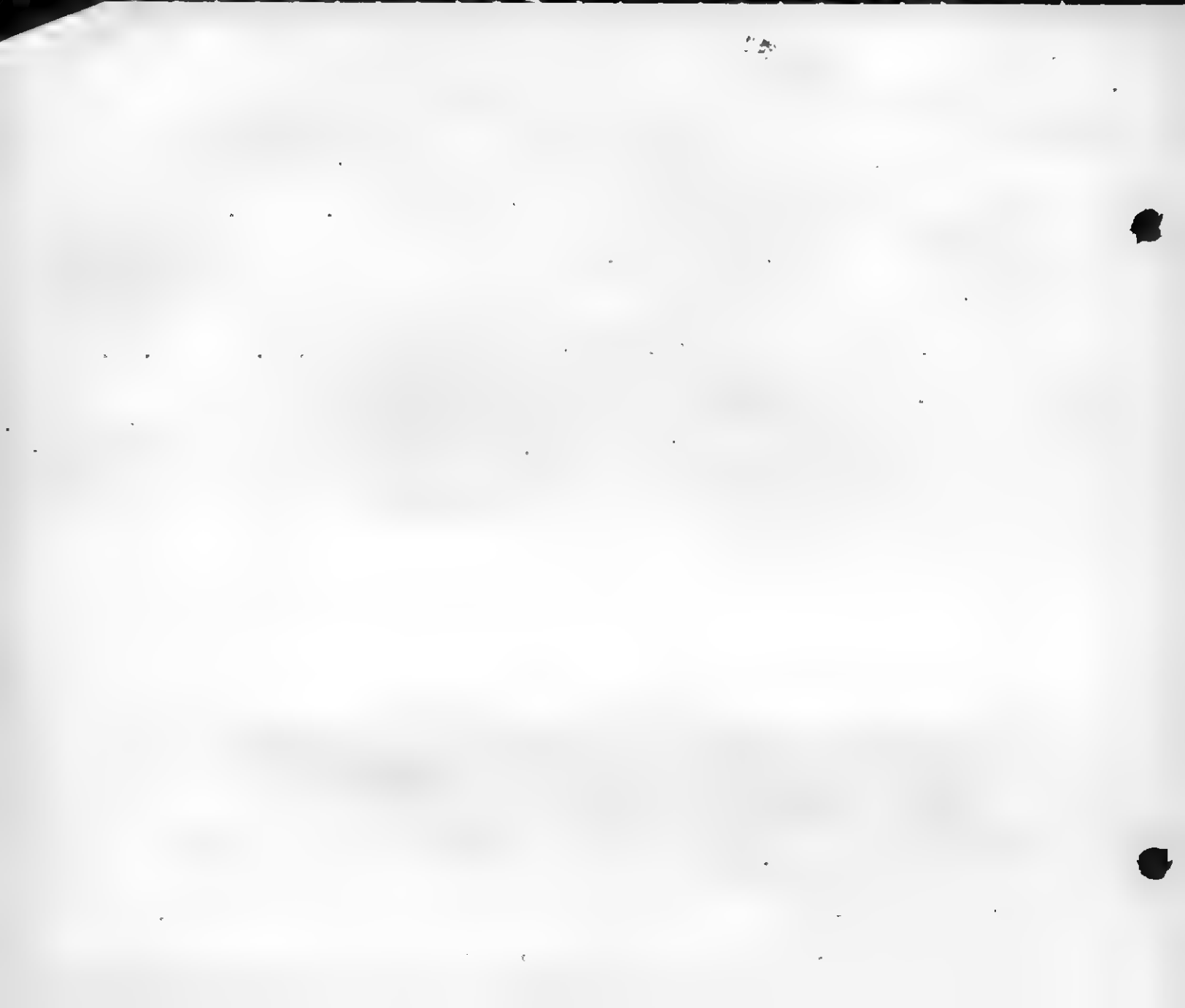
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 8 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2408 DARROW STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALLAN Middle ALEXANDER Last ROSS		4. DATE OF DEATH Month JUNE Day 17 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/3/97
9. AGE (In years lost birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Language Instructor		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME NICHOLAS ROSS		14. MOTHER'S MAIDEN NAME MARIA GABRIAL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 578-54-6791	
INFORMANT Mrs. Margaret S. Ross, 2408 Darrow St.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 20 min 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 1956 to June 1960 that I last saw the deceased alive on June 17 1960 and that death occurred at 6:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Ralph F. Patten M.D.		ADDRESS (Street, city or town, state) 8641-Coleville Road Silver Spring, Maryland	
DATE SIGNED 6/17/60			
PHYSICIAN'S NAME (Type) RALPH F. PATTEN			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6/20/60	22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY	22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.
23. FUNERAL DIRECTOR'S SIGNATURE WAGNER E. PUMPHREY, INC. Raymond A. Ziska		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR JUN 21 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7062

08142

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, D.C.</u> c. LENGTH OF STAY IN b. <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lewisdale,</u> d. STREET ADDRESS <u>2250 Hannon Street</u>	
3. NAME OF DECEASED (Type or print) <u>William Albert Ryon</u>		4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>November 7, 1904</u>		9. AGE (In years last birthday) <u>55</u> yrs. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Medical Doctor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert Ryon</u>		14. MOTHER'S MAIDEN NAME <u>Adelaide Kreps</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, or unknown) (If yes, give war or dates of service) <u>Yes U.S. W.T.</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Emmabelle Ryon</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe congestive heart failure</u> DUE TO (b) <u>Cardiac hypertrophy with acute cardiac dilatation</u> DUE TO (c) <u>Severe coronary artery atherosclerosis with multiple large healed myocardial infarcts.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>—</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>—</u>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>		20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>—</u> p.m. <u>—</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		DATE SIGNED <u>6-24-60</u>	
22a. BURIAL, CREMATION REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6/27/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		22d. LOCATION (City, town, or country) <u>Ft. Myer, Va.</u> (State) <u>—</u>	
23. FUNERAL DIRECTOR <u>THOS. J. KINES Co. 78901 14th St. N.W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
DATE <u>JUN 27 '60</u>		25. REGISTRAR'S SIGNATURE <u>—</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7178

CERTIFICATE OF DEATH

07143

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 22 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. STREET ADDRESS R.D. 2			
3. NAME OF DECEASED (Type or print) First Eugene Middle Franklin Last SALE				4. DATE OF DEATH Month June Day 11 Year 19 60			
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 25 1928	
9. AGE (In years last birthday) 32 yrs		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Missouri				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Arthur Thomas SALE				14. MOTHER'S MAIDEN NAME Zeta Evelyn SKIDMORE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes 1949 - 52		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Helene C. SALE (wife)		Address #2 Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 410 X IMMEDIATE CAUSE (a) Embolism, cerebral DUE TO (b) Myocardial stenosis, rheumatic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Aortic stenosis rheumatic						INTERVAL BETWEEN ONSET AND DEATH 3 days 3 yrs + 3 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from May 20 1960 to June 11 1960 , that (I) (we) last saw the deceased alive on June 11 1960 , and that death occurred at 4:15 AM from the causes and on the date stated above							
22a. SIGNATURE R. G. Thomas LT MC USN				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) R. G. Thomas LT MC USN				22d. ADDRESS U.S. Naval Hospital Staff			
23a. BURIAL CREMATION. REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial-transit 6-11-60				Ridgeburg Cemetery		Orange County, N. J.	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey				25a. REC'D BY REGISTRAR JUN 14 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
25c. ADDRESS 1557 Wisconsin Ave Bethesda, Md							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7179

CERTIFICATE OF DEATH

Reg. Dist. No.

07144

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Laytonsville</u>		c. LENGTH OF STAY IN 1b <u>1 1/2 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hawkins Creamery Rd.</u>		d. STREET ADDRESS <u>Hawkins Creamery Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Peter</u> First <u>Vincent</u> Middle <u>SCHREINER</u> Last		4. DATE OF DEATH <u>June</u> Month <u>3</u> Day <u>1960</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 21 1891</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer - Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	11. BIRTHPLACE (State or foreign country) <u>Iowa</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>George Schreiner</u>	
14. MOTHER'S MAIDEN NAME <u>Annie Ziemehut</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>504 36 9803</u>		17. INFORMANT <u>Mrs Elizabeth Marshall</u> Address <u>Gaithersburg Rt 2 Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure</u> DUE TO (b) <u>Malignant Melanoma</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 1/2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>60</u> , to <u>June 3</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 3</u> , 19 <u>60</u> , and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard A. Yates M.D.</u>		ADDRESS (Street, city or town, state) <u>Olney Md.</u> DATE SIGNED <u>6/3/60</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD A. YATES</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 6, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Rose</u>	22d. LOCATION (City, town, or county) (State) <u>Clonessa Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John L. Mohan</u> ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 8 '60</u> 24b. REGISTRAR'S SIGNATURE <u>C. L. S. Hume</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. O FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07145

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
c. LENGTH OF STAY IN 1b <u>15 minutes</u>		d. STREET ADDRESS <u>5221 Flower Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Eudora</u>		4. DATE OF DEATH <u>6-23-1960</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 15-1891</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.G.</u>	
13. FATHER'S NAME <u>John S. Shields</u>		14. MOTHER'S MAIDEN NAME <u>Alice Paxton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Washington Sanitarium & Hospital</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERALIZED PERITONITIS AND SHOCK</u> DUE TO <u>PERFORATION OF COLON AND RECTUM</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <u>CARCINOMA OF RECTO-SIGMOID COLON</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u></u>		INTERVAL BETWEEN ONSET AND DEATH HOURS <u></u> HOURS <u></u> MONTHS <u></u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brosch</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/27/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SHOOPS CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>HARRISBURG, PENNSYLVANIA</u>	
23. FUNERAL DIRECTOR <u>Raymond A. Zucka</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Huns</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	
DATE <u>JUN 30 '60</u>			

7064

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 25	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>		d. STREET ADDRESS <u>8359 Colesville Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Thomas</u> Last <u>Short</u>		4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-1-85</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS Hours _____ Min _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Retired Govt Employee F.H.A.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mass.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Short</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Burke</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT <u>U.S. Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) <u>Coronary arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>sev'l years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>5/27/52</u> to <u>6/4/50</u> , that I last saw the deceased alive on <u>6/4/50</u> , and that death occurred at <u>11:22 AM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Donald Nelson</u> M.D. <u>10620 Georgia Ave Silver Spring, MD</u> PHYSICIAN'S NAME (Type) <u>DONALD NELSON</u>			
22a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/7/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>	22d. LOCATION (City, town, or county) _____ (State) _____ <u>MONTGOMERY COUNTY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		ADDRESS <u>SILVER SPRING, MD.</u>	24a. REC'D BY REGISTRAR <u>JUN 9 '60</u>
		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death-certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

07148

7180

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 37 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE New Jersey b. COUNTY 67 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deep Water d. STREET ADDRESS 563 Penns Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Kevin Middle Lyle Last SKELTON		4. DATE OF DEATH Month June Day 27 Year 19 60	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-19-60
9. AGE (n years lost birthday) yrs 2 Months 8 Days 8 Hours Min 		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lyle Theodore SKELTON		14. MOTHER'S MAIDEN NAME Mary Ann PAPPAS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT (M) Mrs. Mary Skelton, same as #2 above		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Congenital Heart Disease DUE TO (c) Arteriosclerotic Pulmonary Vascular Return CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this doctor) attended the deceased from May 21 19 60 to June 27 19 60 , that (I) (X) NO last saw the deceased alive on June 27 19 60 , and that death occurred at 2:30 AM, from the causes and on the date stated above. 22a. SIGNATURE D. Harris M. D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b. DATE SIGNED 6-27-60 22c. PHYSICIAN'S NAME (Type) D. HARRIS, LT, MC, USN 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md. 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 23b. DATE THEREOF 6-27-60 23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery 23d. LOCATION (City, town, or county) (State) Salem New Jersey 24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey ADDRESS R. A. Pumphrey Funeral Home, Bethesda, Md. 25a. REC'D BY REGISTRAR JUN 29 '60 25b. REGISTRAR'S SIGNATURE William L. Harris			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 07149

7072

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE			c. LENGTH OF STAY IN 1b 3 YEARS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4822 MORGAN DRIVE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First ALFRED Middle MYATT Last SMITH			4. DATE OF DEATH Month 6th Day 2 Year 1960		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jul 11, 1882		9. AGE (In years last birthday) 78 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10b. KIND OF BUSINESS OR INDUSTRY STORE	11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME HENDERSON FRANK SMITH			14. MOTHER'S MAIDEN NAME MARY P. MYATT		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 242-16-2140	17. INFORMANT MARGARET S. WILLIAMS DAUGHTER Address 4822 MORGAN DR. CHEVY CHASE, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GASTRIC HEMORRHAGE DUE TO PEPTIC ULCER, RECURRENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 6 YEARS DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 8 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) ARTERIOSCLEROSIS GENERALIZED					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from OCTOBER 1959 to JUNE 2, 1960 , that I last saw the deceased alive on MAY 31, 1960 , and that death occurred at 7¹⁰ AM , from the causes and on the date stated above.					
ACTUAL SIGNATURE Robert h. Coale		ADDRESS (Street, city or town, state) 4630 Montgomery Ave. Bethesda Md. DATE SIGNED 6/2/60			
PHYSICIAN'S NAME (Type) ROBERT N. COALE					
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit		22b. DATE THEREOF 6/2/60		22c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery	
22d. LOCATION (City, town, or county) (State) Raleigh, North Carolina		23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland			
24a. REC'D BY REGISTRAR DATE JUN 3 '60		24b. REGISTRAR'S SIGNATURE Arthur L. House			

TO DEED BY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute certificate, writing the word "pending" in pencil in 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7181

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07150

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. STREET ADDRESS <u>4705 Locust Hill Ct.</u>	
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Rushton</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 19, 1952</u>
9. AGE (In years last birthday) <u>7</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>Charlottesville, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph H. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Constance Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Joseph H. Smith (as above) father</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral hemorrhages</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Contusions and Lacerations</u> DUE TO <u> </u> (c) <u>Basal Skull Fracture</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Sudden</u> <u>Sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Pedestrian, reported to have run in st. in front of approaching car.</u>	
20c. TIME OF INJURY Hour <u>3:30</u> p.m. Month, Day, Year <u>6-13 1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) <u>Bethesda</u> (County) <u>Monty</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		DATE SIGNED <u>6-14-60</u>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCANT</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/16/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 16 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7182 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07151

STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN

13 yrs

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

6130 Bradley Blvd

2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)

a. STATE

md

b. COUNTY

montg

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda

d. STREET ADDRESS

6130 Bradley Blvd

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

3. NAME OF DECEASED
(Type or print)

Yowans

Smith

4. DATE OF DEATH

June 9

1960

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED

☒ NEVER MARRIED

8. DATE OF BIRTH

2-25-05

9. AGE (in years IF UNDER 1 YEAR IF UNDER 24 HRS.
last birthday) Months Days Hours Min.

55 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

School Teacher

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N. J.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Wiman H. Smith

14. MOTHER'S MARRIED NAME

Sarah Louise Gowans

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give year or dates of service)

Yes

WW 2

118-07-7062

Police record

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

Myocardial Infarction

Coronary Thrombosis

Coronary Arteriosclerosis

(c)

INTERVAL BETWEEN ONSET AND DEATH

Hours

"

Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Hour a.m.

Month, Day, Year

19

20d. INJURY OCCURRED

While at work

Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ACTUAL SIGNATURE

Frank J. Broschert

M.D.

ASSISTANT MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S NAME (Type)

FRANK J. Broschert

DEPUTY MEDICAL EXAMINER ☒

6-10-60

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

6/17/60

22c. NAME OF CEMETERY OR CREMATORY

Arlington National Cem Arlington, Virginia

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR

Robert A. Pumphrey

Bethesda, Maryland

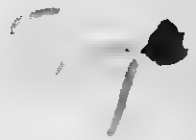
24a. REC'D BY REG STRAR

DATE JUN 17 '60

24b. REGISTRAR'S SIGNATURE

Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



THE UNIVERSITY OF CHICAGO PRESS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7085
CERTIFICATE OF DEATH

07152

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b 2 YEARS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Nursing Home		e. STREET ADDRESS Olney	
3 NAME OF DECEASED (Type or print) First MARY Middle Virginia Last SOPER		4. DATE OF DEATH Month June Day 7 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 5 1875
9. AGE (In years last birthday) 85 yrs		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James S. Benson		14. MOTHER'S MAIDEN NAME Mary Jane Allnutt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Percy Soper		Address Same As # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO (b) Cardiac Failure DUE TO (c) Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 mos. 72 hrs. 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Heart Disease.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from December 1953 to June 7 1960 that (I) (we) last saw the deceased alive on 6/5 1960 , and that death occurred at 7:30 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Frank Y. Jagers Jr.		22b. DATE SIGNED 6/9/60	
22c. PHYSICIAN'S NAME (Type) FRANK Y. JAGGERS JR.		22d. ADDRESS 5707 WISCONSIN AVE	
23a. BURIAL, CREMATION, REMOVAL, ETC. Burial June 10 1960		23b. DATE THEREOF June 10 1960	
23c. NAME OF CEMETERY OR CREMATORY St. Johns		23d. LOCATION (City, town, or county) (State) Olney Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber		25a. REC'D BY REGISTRAR JUN 13 '60	
ADDRESS Laytonsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. H...	



Page 4
after death
The law requires that the death certificate be executed within 24 hours after death.
may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07153

7041 Items 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MD b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LeDeau Gardens Nursing Home		d. STREET ADDRESS 19200 Jones Mills Rd.	
3. NAME OF DECEASED (Type or print) First Mary Middle Stafford Last Stafford		4. DATE OF DEATH Month June Day 13 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) 84 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. KIND OF BUSINESS OR INDUSTRY	
13. BIRTHPLACE (State or foreign country) Washington, D. C.		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME Unknown		16. MOTHER'S MAIDEN NAME Mary Petenia	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		18. SOCIAL SECURITY NO.	
19. INFORMANT Oliver E. Stafford		20. ADDRESS 9900 Jones Mills Rd. C.D.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis, Progressive			
333X DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from March 1959 to June 13 1960 that (I) (we) last saw the deceased alive on June 7 1960 and that death occurred at 8:05 pm from the causes and on the date stated above.			
22a. SIGNATURE Robert T. Thibadeau M.D.			
22b. DATE SIGNED Jun 13 60			
22c. PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D.			
22d. ADDRESS 10609 Concord St., Kensington, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF 6-16-60			
23c. NAME OF CEMETERY OR CREMATORY t. J. Br's Cem.			
23d. LOCATION (City, town, or county) (State) East Glenn Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Thomas G. Necton			
25a. REC'D BY REGISTRAR JUN 21 '60			
25b. REGISTRAR'S SIGNATURE Arthur J. Kinn			

51

7183

CERTIFICATE OF DEATH

Reg. Dist. No. 07154

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 15 <u>8 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. STREET ADDRESS <u>306 Grubb Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Roy Steinling</u>		4. DATE OF DEATH <u>June 4 1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 4 1960</u>
9. AGE (In years last birthday) <u>16</u>		10. IF UNDER 1 YEAR: Months <u>16</u> Days <u>18</u> Min <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Steinling</u>		14. MOTHER'S MAIDEN NAME <u>Ruth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>16 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>1960</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4 June 1960</u> to <u>4 June 1960</u> , that I last saw the deceased alive on <u>4 June 1960</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>8218 Wisconsin Ave Bethesda Md</u>	
DATE SIGNED <u>4 June 1960</u>			
PHYSICIAN'S NAME (Type or print)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>	22b. DATE THEREOF <u>6-4-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Suburban hospital</u>	22d. LOCATION (City, town, or county) (State) <u>8600 Old Georgetown Rd. Bethesda, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		24a. REC'D BY REGISTRAR <u>DATE 6-6-60</u>	
ADDRESS <u>Suburban Hospital 8600 Old Georgetown Rd Bethesda, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7

21

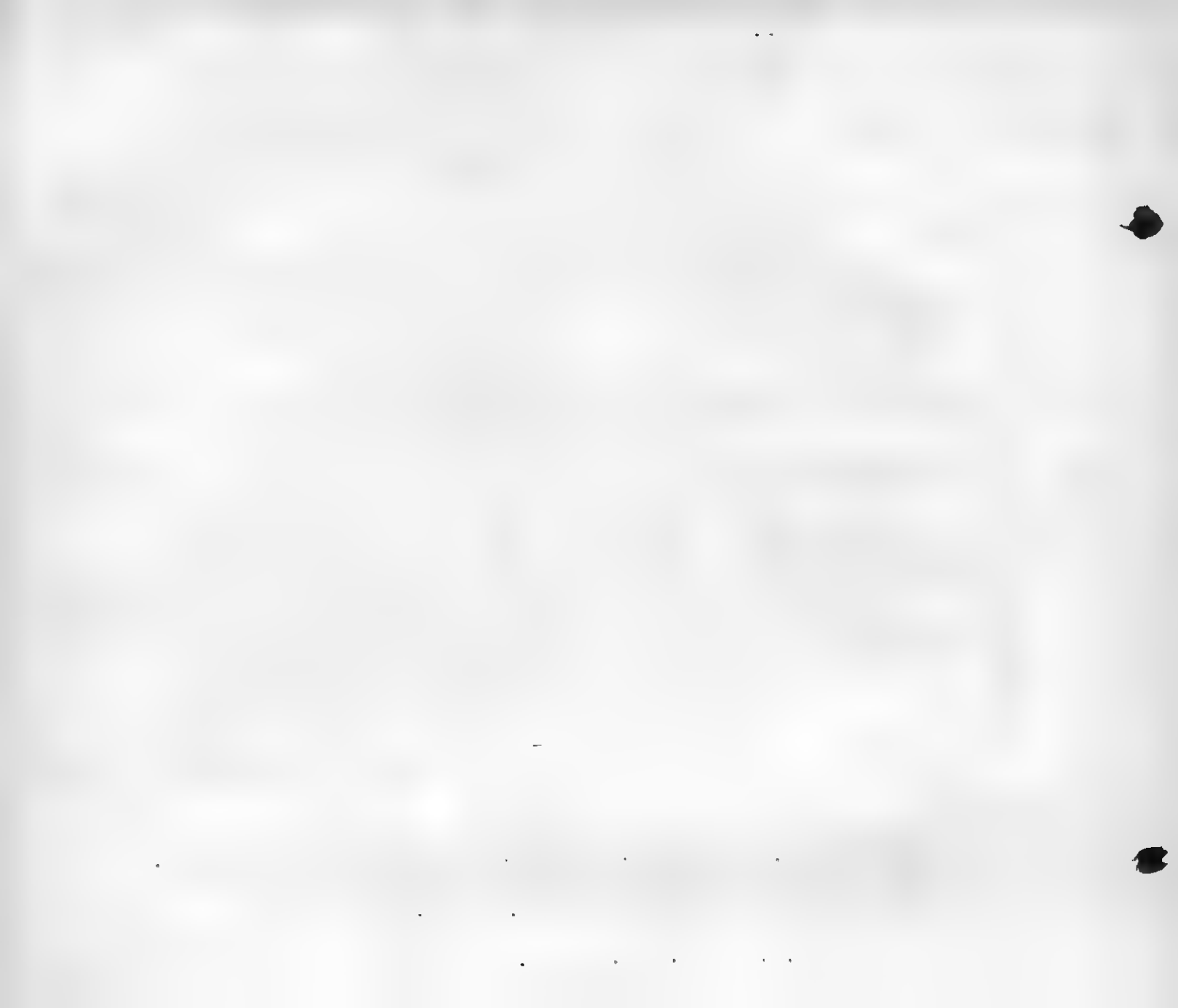
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
7-15-60 ans 26 See: Birth Cert. at									
7065									
CERTIFICATE OF DEATH									
Reg. Dist. No. 07155									
1. PLACE OF DEATH a. COUNTY MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park					c. LENGTH OF STAY IN 1b				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanatorium and Hospital					d. STREET ADDRESS Rural Route #1				
3. NAME OF DECEASED (Type or print) First Middle Last Strickland					4. DATE OF DEATH Month Day Year 6 20 1960				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6/20/60		9. AGE (In years last birthday) yr.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Hester Strickland					14. MOTHER'S MAIDEN NAME Violet Elsie Howington				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Hospital Records					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTE TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 2:25 am 6-20 19 60 to 11:15 am 6-20 19 60 , that I last saw the deceased alive on June 20 19 60 , and that death occurred at 11:15 am , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED									
ACTUAL SIGNATURE Charles R. Hughes, M.D.									
PHYSICIAN'S NAME (Type) Charles R. Hughes, M.D., 8226 Fenton Street, Silver Spring, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town or county) (State)			
cremation		6-21-60		Washington San. & Hosp.		Takoma Park Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Robert Hare, M.D., Wash. San. & Hosp.					24a. REC'D BY REGISTRAR DATE JUN 28 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Frank		

2075388XVI



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

7184
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07156
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 2 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
3. NAME OF DECEASED (Type or print) Ralph McMath Tucker Jr.		d. STREET ADDRESS 5911 Harwick Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ralph McMath Tucker Jr.		4. DATE OF DEATH June 17 1960	
5. SEX Male		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 30, 1950	
9. AGE (In years last birthday) 9 yrs.		10. UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student		12. KIND OF BUSINESS OR INDUSTRY Maryland	
13. FATHER'S NAME Ralph McMath Tucker		14. MOTHER'S MAIDEN NAME XXXXXXXX Joy Hebert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Father		Address Ralph Tucker 5911 Harwick Rd. Bethesda, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Herniation of Brain Stem DUE TO (b) Cerebral Edema DUE TO (c) Cerebral Contusion		INTERVAL BETWEEN ONSET AND DEATH Sudden Sudden 2 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Right pneumothorax and intrapulmonary hemorrhage		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Reported ran across street in front of approaching car	
20c. TIME OF INJURY Hour 5-00 a.m. Month, Day, Year 6-17 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street		20f. (City or town) Bethesda (County) Monty (State) md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Blosch		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. Blosch		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED June 18 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/21/60	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR JUN 21 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7075

CERTIFICATE OF DEATH

Reg. Dist. No. 07157

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b 07 Gaithersburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 330 E. Diamond Ave.		d. STREET ADDRESS 330 E. Diamond Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HENRY (NMI) WALTON		4. DATE OF DEATH Month June Day 15 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1879
9. AGE (In years last birthday) 81 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Walton		14. MOTHER'S MAIDEN NAME Jane Irwin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Joseph Walton-Item # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE 30 years DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prostatism with chronic renal failure			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from AUGUST 19, 1958 to JUNE 16, 1960 , that I last saw the deceased alive on JUNE 15, 1960 , and that death occurred at 2 P. M. , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) Gordon S. Rosenberger M.D. 310 W. MONTGOMERY AVE. ROCKVILLE, MARYLAND		DATE SIGNED 16 June 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 6/18/60	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Prince George Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler		24a. REC'D BY REGISTRAR DATE JUN 20 '60	
24b. REGISTRAR'S SIGNATURE Gordon S. Rosenberger			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07158

7042

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>20 yrs.</u>		d. STREET ADDRESS <u>1811 Myrtle Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1811 Myrtle Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marian Cecilian Washington</u>		DATE OF DEATH <u>June 24 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-12-1910</u>
9. AGE (In years) <u>50</u> yrs. If UNDER 1 YEAR If UNDER 24 HRS		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Maurice McCulliffe</u>		14. MOTHER'S MAIDEN NAME <u>Matel Hammer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>Margaret McCulliffe</u>	
17. INFORMANT <u>Margaret McCulliffe</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u>		(c) <u></u>	
PART II. OTHER SIGNIF. CANT COND. TIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT. ON GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-28-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR <u>F. J. Collins</u>		24a. REC'D BY REGISTRAR <u>Francis J. Collins</u>	
24b. REGISTRAR'S SIGNATURE <u>Francis J. Collins</u>		DATE <u>JUN 27 '60</u>	

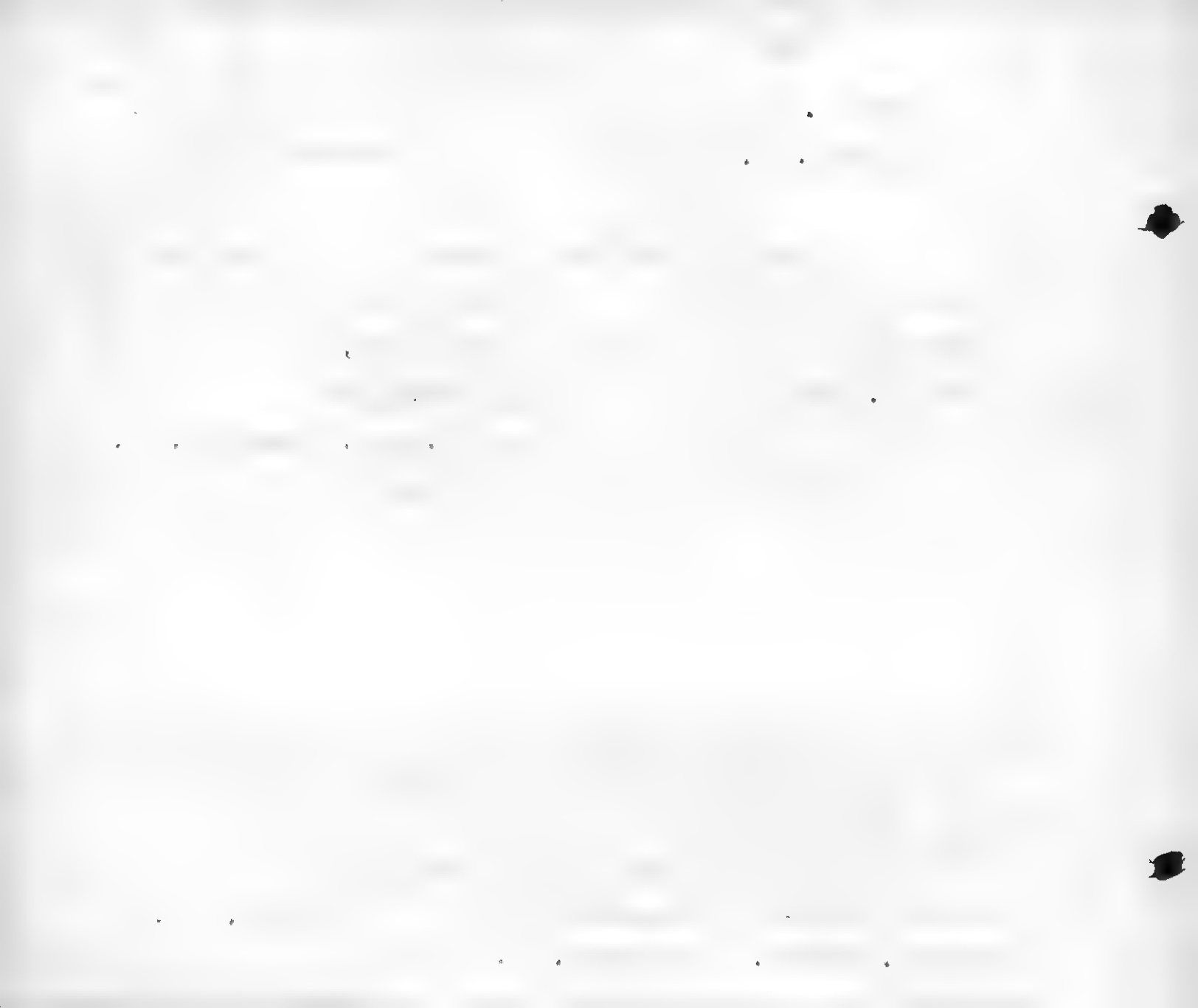
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7076

CERTIFICATE OF DEATH

Reg. Dist. No. 07159

1. PLACE OF DEATH a. COUNTY Montg MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montg,	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg. Md.		c. LENGTH OF STAY IN 1b 40Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS Summit Ave	
3. NAME OF DECEASED (Type or print) First Lillian Middle Nevada Last Wells		4. DATE OF DEATH Month June Day 16 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26-1879
9. AGE (In years last birthday) 80 yrs		10. IF UNDER 1 YEAR Months 10 Days 18	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Home Work	
11. BIRTHPLACE (State or foreign country) Spencer Va,		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Berry D. Grogan		14. MOTHER'S MAIDEN NAME Virginia Dare	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
INFORMANT Robert L. Wells.		Address Rockville. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Vascular Accident DUE TO (c) Generalized Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH sudden 1 wk years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 2 , 19 60 , to June 16 , 19 60 , that I last saw the deceased alive on June 15 , 19 60 , and that death occurred at 1:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Frank J. Broschew M.D.			
PHYSICIAN'S NAME (Type) FRANK J. Broschew		Gaithersburg Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-16-60	22c. NAME OF CEMETERY OR CREMATORY ParkLawn	22d. LOCATION (City, town, or county) (State) Rockville. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. Gaithersburg. Md.		24a. REC'D BY REGISTRAR JUN 20 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7185

CERTIFICATE OF DEATH

07160

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b OLNEY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BEULAH Middle MAY Last WHITE		4. DATE OF DEATH Month JUNE Day 6 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 1, 1908
9. AGE (In years lost birthday) 51 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11b. KIND OF BUSINESS OR INDUSTRY	
11c. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ARTHUR MILLER		14. MOTHER'S MAIDEN NAME MISSOURI EVERETT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT HOSPITAL RECORDS		Address OLNEY, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma DUE TO (b) Acute viral hepatitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral Bronchopneumonia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 2 19 60 to June 6 19 60 , that (I) last saw the deceased alive on June 6 19 60 , and that death occurred at 10:28 P.M. from the causes and on the date stated above.			
22a. SIGNATURE G. F. Meadors, Jr. M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) G. F. MEADORS, JR. M. D.		22d. ADDRESS DAMASCUS, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-10-60	
23c. NAME OF CEMETERY OR CREMATORY Bayard W. Va		23d. LOCATION (City, town, or county) (State) Bayard W. Va	
24. FUNERAL DIRECTOR'S SIGNATURE Deaf Funeral Home		25a. REC'D BY REGISTRAR June 9 1960	
25b. REGISTRAR'S SIGNATURE C. W. & K. H. W.		25c. ADDRESS 4812 Ga. Ave. N.W. D.C.	

X

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

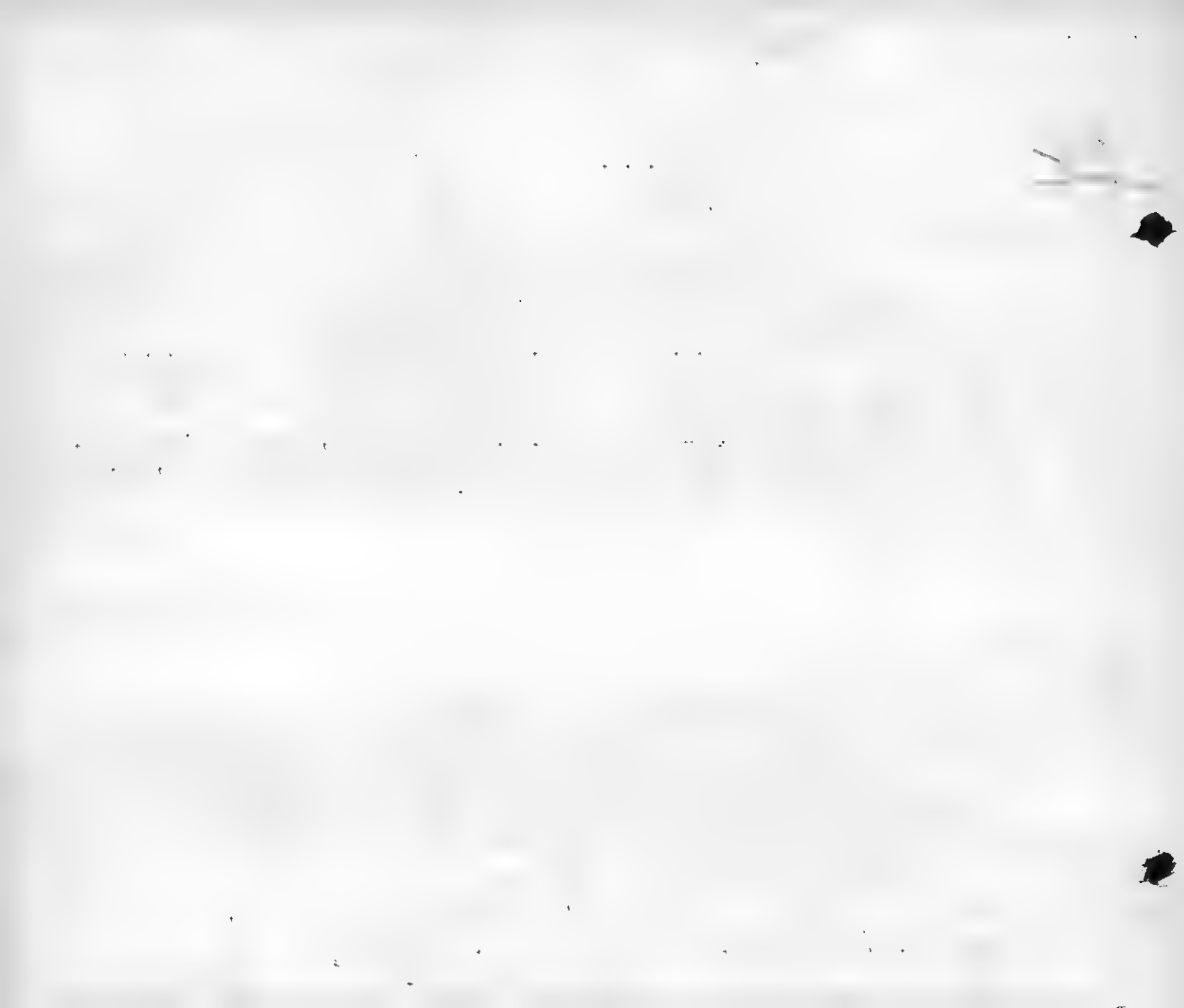
VR A15 (4)
15M 9/59

7066

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07161

1 PLACE OF DEATH a COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a STATE MARYLAND b COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. & HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
f. STREET ADDRESS 2302 BLUE RIDGE AVENUE		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First ROBERT Middle YOUNG Last WHITE		4. DATE OF DEATH Month JUNE Day 9 Year 19 60	
5 SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10/1/13
9 AGE (In years lost birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus driver		10b. KIND OF BUSINESS OR INDUSTRY D.C. Transit Co.	11. BIRTHPLACE (State or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME JOHN WHITE	
14 MOTHER'S MAIDEN NAME MARY YOUNG		15 WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES WW #2	
16 SOCIAL SECURITY NO 237-12-1337		17 INFORMANT Mrs. M. Lucille White, 2302 Blue Ridge Ave.	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Increased intracranial pressure DUE TO 199.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Brain tumor DUE TO (c) 1 year		INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac disease		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 15, 1960 to June 9, 1960 , that (I) (we) last saw the deceased alive on June 6, 1960 , and that death occurred at 8 A.M. from the causes and on the date stated above			
22a. SIGNATURE Harvey H. Ammerman M.D.		22b. DATE SIGNED June 9-1960	
22c. PHYSICIAN'S NAME (Type) Harvey H. Ammerman		22d. ADDRESS 2025 Eye St. N.W. WASH D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/13/60	
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY		23d. LOCATION (City, town or county) (State) ARLINGTON, VIRGINIA	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pimpsey, Inc.		25a. REC'D BY REGISTRAR DATE JUN 14 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume			



TO HONORARY OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7086

CERTIFICATE OF DEATH

Reg. Dist. No.

07162

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b 17	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5002 Bangor Drive		d. STREET ADDRESS 5002 Bangor Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Eugene Middle G Last Wiedman		4. DATE OF DEATH Month June Day 4 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/26/1890
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 4 Days 8 Hours Min. 	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Wiedman		14. MOTHER'S MAIDEN NAME Caroline Pficemyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 147-26-1306	
17. INFORMANT William Wiedman-son-same 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Anasarc DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b). Metastatic carcinoma of the pancreas DUE TO (c). INTERVAL BETWEEN ONSET AND DEATH 2 weeks 12 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 27 , 19 59 , to 3 June , 19 60 , that I last saw the deceased alive on 3 June , 19 60 , and that death occurred at 7:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10511 Summit Ave DATE SIGNED 6/4/60 ACTUAL SIGNATURE Horace W. Bernton, MD PHYSICIAN'S NAME (Type) Horace W. Bernton, M.D. Kensington, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/8/60	
22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR DATE JUN 8 '60	
ADDRESS Bethesda, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

12

12

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07163

7099

Items 6, 13, 14, 15 missing 6-13-60 et

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Hayes</u> Middle <u>Williams</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/10/1925</u>
9. AGE (in years last birthday) <u>34</u> yrs		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> M'n <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grave digger</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Augustus Williams</u>		14. MOTHER'S MAIDEN NAME <u>Lulu Williams (Maiden name)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Police Record</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hemorrhage</u> DUE TO <u>Severance of left jugular vein</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Shot gun and stab wound in left chest</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Unknown at this time</u>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year <u>6/3/60</u> 19 <u> </u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <u>home</u>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rockville</u>			
20f. (City or town) <u>Montg. Md.</u> (County) <u> </u> (State) <u> </u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-7-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant</u>		22d. LOCATION (City, town, or county) <u>Norbeck, Md.</u> (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
DATE <u>JUN 8 '60</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

X



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07164

7043

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>305 Lanark Way</u>		d. STREET ADDRESS <u>305 Lanark Way</u>	
3. NAME OF DECEASED (Type or print) <u>Mary Ann Williams</u>		4. DATE OF DEATH <u>June 9 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-1-1906</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Earley</u>		14. MOTHER'S MAIDEN NAME <u>Mary Sullivan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-30-2305</u>	
17. INFORMANT <u>David Williams</u>		Address <u>Ilm 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Hypertension</u> (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. _____ p.m. _____	Month, Day, Year: _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____
20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/11/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>		22d. LOCATION (City, town, or country) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR <u>WARNER E. PIMPREY, INC.</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Hines</u>	
Address <u>SILVER SPRING, MD.</u>		DATE <u>JUN 14 '60</u>	

7186

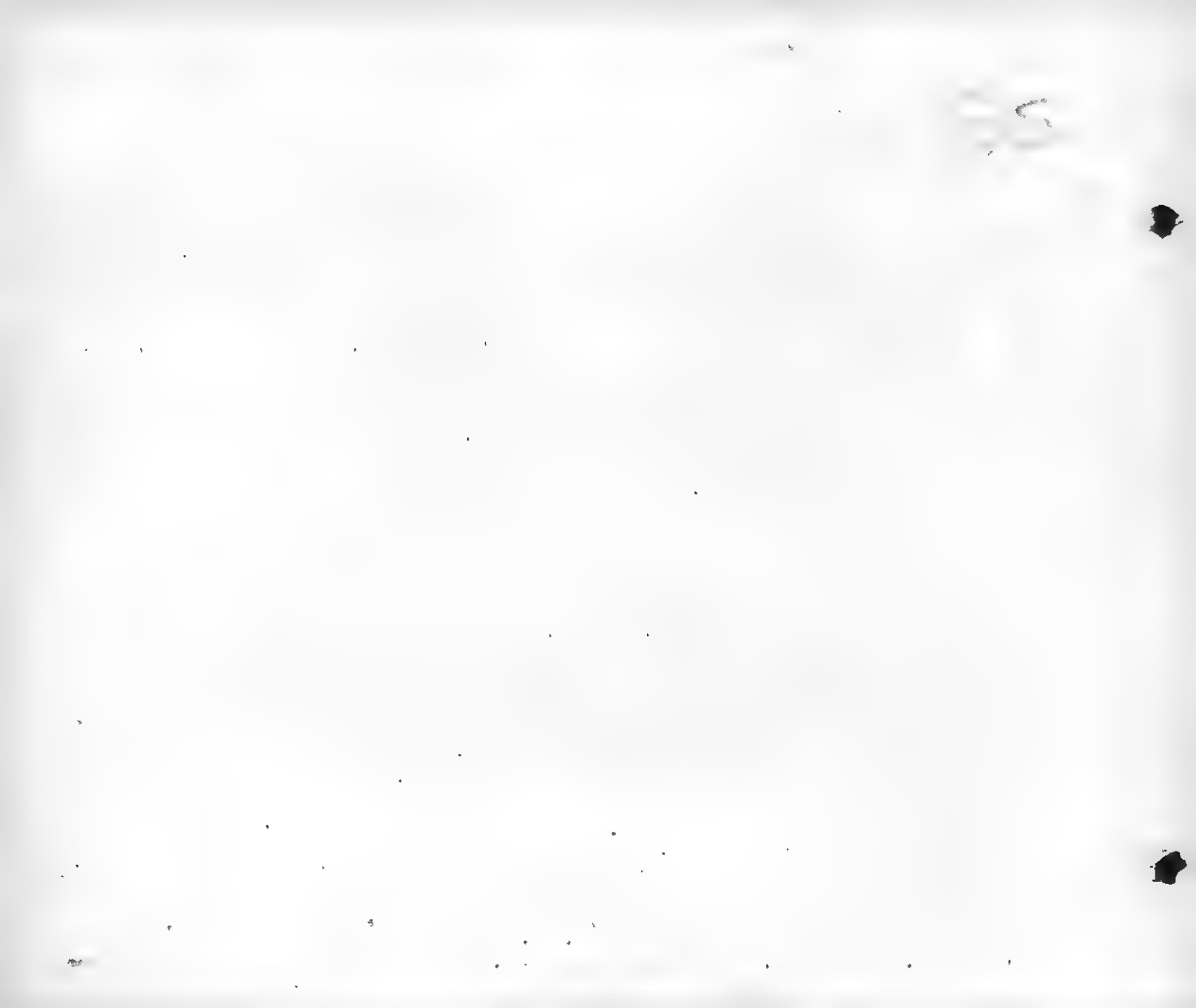
CERTIFICATE OF DEATH

02165

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6211 Kennedy Drive		d. STREET ADDRESS 6211 Kennedy Drive	
3. NAME OF DECEASED (Type or print) First Mary Middle Crete Last Willis		4. DATE OF DEATH Month June Day 22 Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/6/84
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 11 Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Elmira, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew McConnell		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ----	
17. INFORMANT John C. Willis		5826 Osceola Rd., High Point, Md. same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral emboli DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Generalized Arterio Sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4-5 days 4-5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Cerebral Hemorrhage 7 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 6, 1944 , to June 22, 1960 that I last saw the deceased alive on June 21, 1960 , and that death occurred at 3:55 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. B. Wardrop MD M.D.		ADDRESS (Street, city or town, state) 800 Pershing Drive Silver Spring Md DATE SIGNED 6/22/60	
PHYSICIAN'S NAME (Type) W. B. WARDROP, MD		800 PERSHING DRIVE SILVER SPRING MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/24/60	22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington 9, D.C.		24a. REC'D BY REGISTRAR JUN 22 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7187

CERTIFICATE OF DEATH

07167

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE -- b. COUNTY --	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, DC	
d. NAME OF HOSPITAL (If in hospital, give street address) OR INSTITUTION 9200 Wisconsin Avenue Congressional Manor Sanitarium		d. STREET ADDRESS 3823 Veazey Street N.W.	
3. NAME OF DECEASED (Type or print) First Lola Middle E Last Wood		4. DATE OF DEATH Month June Day 24 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/5/1885
9. AGE (In years last birthday) 75 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Boarman		14. MOTHER'S MAIDEN NAME Unobtainable	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO no	
17. INFORMANT George E. Wood - Same #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemiplegia, right, acute DUE TO (b) Hypertension, moderately severe DUE TO (c) Arteriosclerosis, general, advanced Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Diabetes Mellitis, moderate		INTERVAL BETWEEN ONSET AND DEATH 5 days 3 yrs + 5 yrs +	
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) ---	
20c. TIME OF INJURY Month, Day, Year Hour a. m. --- 19 --- p. m. ---		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that (I) (this hospital) attended the deceased from 4-10-1957 to June 24, 1960 that (I) (we) last saw the deceased alive on June 24, 1960 and that death occurred at 8:55 AM , from the causes and on the date stated above			
22a. SIGNATURE Stewart Clapp M.D.		22b. DATE SIGNED 6/24/60	
22c. PHYSICIAN'S NAME (Type) Stewart Clapp M.D.		22d. ADDRESS 3921 Ingomar St NW	
23a. BURIAL, CREMATION, or MOVEMENT (Specify) Burial		23b. DATE THEREOF 6/27/60	
23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St. N.W.		25a. REC'D BY REGISTRAR DATE JUN 27 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07168

7188

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pockessville RFD
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pat. R. Edmund Ferry

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE md b. COUNTY Frederick
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick
d. STREET ADDRESS 65 S. Market St. *
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Daniel Allen Woods
4. DATE OF DEATH June 5 1960
5. SEX male 6. COLOR OR RACE white 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH Jan 16 - 1950 9. AGE (in years last birthday) 10 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student 10b. KIND OF BUSINESS OR INDUSTRY School 11. BIRTHPLACE (State or foreign country) md 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Daniel C Woods 14. MOTHER'S MAIDEN NAME Dorothy Springs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service) 16. SOCIAL SECURITY NO. None 17. INFORMANT Police Record Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Asphyxia
R50-X DUE TO drowning
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sudden

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fishing in Pat R. 6-1-60 when motor boat upset
20c. TIME OF INJURY Month, Day, Year 6:30 p.m. 6-1-1960 20d. INJURY OCCURRED While ☐ Not While ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Pat R. R. 20f. (City or town) Knotville Falls (County) Frederick (State) md

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 6-5-60

EXAMINER'S SIGNATURE Frank J. Bruschant M.D. EXAMINER'S NAME (Type) FRANK J. Bruschant Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF June 7, 1960 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery 22d. LOCATION (City, town, or country) Frederick, Maryland

23. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland ADDRESS Frederick, Maryland 24a. REC'D BY REGISTRAR JUN 10 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Hines



7189

CERTIFICATE OF DEATH

Reg. 027169

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>FAIRLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAIRLAND NURSING Home</u>		d. STREET ADDRESS <u>5026-7 1st W.</u>	
3. NAME OF DECEASED (Type or print) First <u>LOUIS</u> Middle <u>WORONOW</u> Last <u>WORONOW</u>		4. DATE OF DEATH Month <u>6</u> Day <u>26</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 14, 1884</u>
9. AGE (In years last birthday) <u>75</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
INFORMANT <u>FANNIE WORONOW</u>		Address <u>5026-7-N W</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>38</u> to <u>June 26, 1960</u> that I last saw the deceased alive on <u>June 12, 1960</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. P. Lasky</u>		DATE SIGNED <u>6/26/60</u>	
PHYSICIAN'S NAME (Type) <u>BENJAMIN P. LASKY</u>		ADDRESS (Street, city or town state) <u>2025 Eye St NW Wash DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE OF <u>6/28/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ADAMS ISRAEL</u>	22d. LOCATION (City, town, or county) (State) <u>DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edith - El Norton</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 28 '60</u>	
ADDRESS <u>4217-9 Ave.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



7190

CERTIFICATE OF DEATH

07170

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5013 Benton Avenue		d. STREET ADDRESS 5013 Benton Avenue	
3. NAME OF DECEASED (Type or print) First REBECCA Middle WOSTEIN Last WOSTEIN		4. DATE OF DEATH Month June Day 9 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1888
9. AGE (In years last birthday) 72 yrs		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---	11 BIRTHPLACE (State or foreign country) Poland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Benjamin Finkelstein	
14. MOTHER'S MAIDEN NAME Gertrude ---		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16 SOCIAL SECURITY NO. ---		INFORMANT Ben Wostein - Son - 1794 Verbena St., NW	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPOSTATIC PNEUMONIA DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) Exacerbated arteriosclerosis DUE TO (c) Diabetes			INTERVAL BETWEEN ONSET AND DEATH 4 days 10 yrs 20 "
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 1960 , to June 9, 1960 , that I last saw the deceased alive on 6-8-60 , 1960, and that death occurred at 8:45 A.M. , from the causes and on the date stated above. 6-9-60 ADDRESS (Street, city or town, state) 3701- Conn Ave NW Wash DC DATE SIGNED 6-9-60			
ACTUAL SIGNATURE Herbert L. Tanenbaum, M.D.		PHYSICIAN'S NAME (Type) Herbert L. Tanenbaum, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-10-60	22c. NAME OF CEMETERY OR CREMATORY Hebrew Mt. Carmel Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE B. Panzansky & Sons - 3501 14th St., NW		24a. REC'D BY REGISTRAR DATE JUN 13 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

X

1

M

075

7067

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07171

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY CO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. LENGTH OF STAY IN 1b 1 Hour 40			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JACOB ZAWATSKY				4. DATE OF DEATH Month Day Year JUNE 25 1960			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May-25-96	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUILDER		10b. KIND OF BUSINESS OR INDUSTRY HOME-BUILDER		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Abraham Zawatsky				14. MOTHER'S MAIDEN NAME Anna Wiggatoff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 130-07-0875		17. INFORMANT Address Mrs Pauline Zawatsky (wife)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) GENERALIZED ARTERIOSCLEROSIS						INTERVAL BETWEEN ONSET AND DEATH 6 HOURS 10 YEARS 15 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 1954 to 6/23/60 , that (I) (we) last saw the deceased alive on 6/23/60 , and that death occurred at 4:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE Samuel D. Loube M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) SAMUEL D. LOUBE, M.D.				22d. ADDRESS 2025 EYE ST, N.W., WASHINGTON 6, DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/26/1960		23c. NAME OF CEMETERY OR CREMATORY DETH SHOLOM Cem.		23d. LOCATION (City, town, or county) (State) CAP. HTS. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Bredberg ADDRESS 1717 9th Ave NW				25a. REC'D BY REGISTRAR DATE JUN 28 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

40

7191

CERTIFICATE OF DEATH

Reg. Dist. No. 07172

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Mt. Airy,				c. LENGTH OF STAY IN 1b 3 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brown Church Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last George Melvin Zimmerman				4. DATE OF DEATH Month Day Year June 4 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1883	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm		11. BIRTHPLACE (State or foreign country) Feagaville, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward J. Zimmerman				14. MOTHER'S MAIDEN NAME Amanda Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-30-4057		INFORMANT Address Martz E. Zimmerman, Germantown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Damascus, Md.		(County)	(State)	
21. I certify that I attended the deceased from April 30, 19 60 to June 4, 19 60 that I last saw the deceased alive on May 30, 19 60 , and that death occurred at 4 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James P. Kerr				ADDRESS (Street, city or town, state) Damascus, Md.			
PHYSICIAN'S NAME (Type) James P. Kerr				DATE SIGNED 6/5/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 6, 1960	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Frederick, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Oliver L. Wolsunth				ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE JUN 8 '60	24b. REGISTRAR'S SIGNATURE Charles S. Howard

TO NO LOCAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

X